

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 225 Session of  
2021

INTRODUCED BY PHILLIPS-HILL, MARTIN, J. WARD, MENSCH, COLLETT,  
MUTH, KANE, STEFANO, AUMENT, CAPPELLETTI, BAKER, BROOKS,  
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MASTRIANO, SANTARSIERO, KEARNEY, SCHWANK, DUSH, COMMITTA,  
FLYNN, L. WILLIAMS AND DILLON, MARCH 18, 2021

AS AMENDED ON SECOND CONSIDERATION, HOUSE OF REPRESENTATIVES,  
OCTOBER 25, 2022

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An  
2 act relating to insurance; amending, revising, and  
3 consolidating the law providing for the incorporation of  
4 insurance companies, and the regulation, supervision, and  
5 protection of home and foreign insurance companies, Lloyds  
6 associations, reciprocal and inter-insurance exchanges, and  
7 fire insurance rating bureaus, and the regulation and  
8 supervision of insurance carried by such companies,  
9 associations, and exchanges, including insurance carried by  
10 the State Workmen's Insurance Fund; providing penalties; and  
11 repealing existing laws," ~~in quality health care~~ <--  
12 ~~accountability and protection, further providing for~~  
13 ~~definitions, for responsibilities of managed care plans, for~~  
14 ~~financial incentives prohibition, for medical gag clause~~  
15 ~~prohibition, for emergency services, for continuity of care,~~  
16 ~~providing for medication assisted treatment, further~~  
17 ~~providing for procedures, for confidentiality, for required~~  
18 ~~disclosure, providing for medical policy and clinical review~~  
19 ~~criteria adopted by insurer, MCO or contractor, further~~  
20 ~~providing for internal complaint process, for appeal of~~  
21 ~~complaint, for complaint resolution, for certification, for~~  
22 ~~operational standards, providing for step therapy~~  
23 ~~considerations, for prior authorization review and for~~  
24 ~~provider portal, further providing for internal grievances~~  
25 ~~process, for records, for external grievance process, for~~  
26 ~~prompt payment of claims, for health care provider and~~  
27 ~~managed care plan, for departmental powers and duties, for~~  
28 ~~penalties and sanctions, for compliance with National~~

<--

1 ~~Accrediting Standards; and making editorial changes. IN~~  
2 ~~QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION, FURTHER~~  
3 ~~PROVIDING FOR DEFINITIONS, FOR RESPONSIBILITIES OF MANAGED~~  
4 ~~CARE PLANS, FOR FINANCIAL INCENTIVES PROHIBITION, FOR MEDICAL~~  
5 ~~GAG CLAUSE PROHIBITION, FOR EMERGENCY SERVICES, FOR~~  
6 ~~CONTINUITY OF CARE, FOR PROCEDURES, FOR CONFIDENTIALITY, FOR~~  
7 ~~REQUIRED DISCLOSURE AND FOR INTERNAL COMPLAINT PROCESS,~~  
8 ~~PROVIDING FOR INTERNAL COMPLAINT PROCESS FOR ENROLLEES,~~  
9 ~~FURTHER PROVIDING FOR APPEAL OF COMPLAINT, FOR COMPLAINT~~  
10 ~~RESOLUTION, FOR CERTIFICATION AND FOR OPERATIONAL STANDARDS,~~  
11 ~~PROVIDING FOR UTILIZATION REVIEW STANDARDS, FURTHER PROVIDING~~  
12 ~~FOR INTERNAL GRIEVANCE PROCESS, FOR EXTERNAL GRIEVANCE~~  
13 ~~PROCESS AND FOR RECORDS, PROVIDING FOR ADVERSE BENEFIT~~  
14 ~~DETERMINATIONS, FURTHER PROVIDING FOR PROMPT PAYMENT OF~~  
15 ~~CLAIMS, FOR HEALTH CARE PROVIDER AND MANAGED CARE PLAN~~  
16 ~~PROTECTION, FOR DEPARTMENTAL POWERS AND DUTIES, FOR~~  
17 ~~CONFIDENTIALITY AND FOR PENALTIES AND SANCTIONS, PROVIDING~~  
18 ~~FOR REGULATIONS AND FURTHER PROVIDING FOR COMPLIANCE WITH~~  
19 ~~NATIONAL ACCREDITING STANDARDS AND FOR EXCEPTIONS; MAKING~~  
20 ~~REPEALS; AND MAKING EDITORIAL CHANGES.~~

21 The General Assembly of the Commonwealth of Pennsylvania  
22 hereby enacts as follows:

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23 ~~Section 1. The definitions of "complaint," "drug formulary,"~~  
24 ~~"enrollee," "grievance," "health care service," "prospective~~  
25 ~~utilization review," "provider network," "retrospective~~  
26 ~~utilization review," "utilization review" and "utilization~~  
27 ~~review entity" in section 2102 of the act of May 17, 1921~~  
28 ~~(P.L.682, No.284), known as The Insurance Company Law of 1921,~~  
29 ~~are amended and the section is amended by adding definitions to~~  
30 ~~read:~~

31 ~~Section 2102. Definitions. As used in this article, the~~  
32 ~~following words and phrases shall have the meanings given to~~  
33 ~~them in this section:~~

34 \* \* \*

35 ~~"Administrative policy." A written document or collection of~~  
36 ~~documents reflecting the terms of the contractual or operating~~  
37 ~~relationship between an insurer, MCO, contractor and a health~~  
38 ~~care provider.~~

39 ~~"Administrative denial." A denial of prior authorization,~~  
40 ~~coverage or payment based on a lack of eligibility, failure to~~

1 ~~submit complete information or other failure to comply with~~  
2 ~~written administrative standards for the administration of~~  
3 ~~benefits under a health insurance policy, MCO contract or CHIP~~  
4 ~~contract. The term does not include a denial based on medical~~  
5 ~~necessity.~~

6 ~~"Adverse benefit determination." A determination by an~~  
7 ~~insurer, MCO, contractor or a utilization review entity~~  
8 ~~designated by the insurer, MCO or contractor that a health care~~  
9 ~~service has been reviewed and, based upon the information~~  
10 ~~provided, does not meet the insurer's, MCO's or contractor's~~  
11 ~~requirements for medical necessity, appropriateness, health care~~  
12 ~~setting, level of care or effectiveness and the requested~~  
13 ~~service or payment for the service is therefore denied, reduced~~  
14 ~~or terminated.~~

15 \* \* \*

16 ~~"Applicable governmental guidelines." Clinical practice and~~  
17 ~~associated guidelines issued under the authority of the United~~  
18 ~~States Department of Health and Human Services, United States~~  
19 ~~Food and Drug Administration, Centers for Disease Control and~~  
20 ~~Prevention, Department of Health or other similarly situated~~  
21 ~~Federal or State agency, department or subunit thereof focused~~  
22 ~~on the provision or regulation of medical care, prescription~~  
23 ~~drugs or public health within the United States.~~

24 ~~"Children's Health Insurance Program" or "CHIP." The~~  
25 ~~children's health care program under Article XXIII A.~~

26 ~~"CHIP contract." The agreement between an insurer and the~~  
27 ~~Department of Human Services to provide for services to a CHIP~~  
28 ~~enrollee.~~

29 \* \* \*

30 ~~"Clinical review criteria." The set of written screening~~

~~1 procedures, decision abstracts, clinical protocols and practice  
2 guidelines used by an insurer, MCO or contractor to determine  
3 the necessity and appropriateness of health care services.~~

~~4 "Closely related service." One or more health care services  
5 subject to prior authorization that are closely related in  
6 purpose, diagnostic utility or designated health care billing  
7 code and provided on the same date of service such that a  
8 prudent health care provider, acting within the scope of the  
9 health care provider's license and expertise, might reasonably  
10 be expected to perform such service in conjunction with or in  
11 lieu of the originally authorized service in response to minor  
12 differences in observed patient characteristics or needs for  
13 diagnostic information that were not readily identifiable until  
14 the health care provider was actually performing the originally  
15 authorized service. The term does not include an order for or  
16 administration of a prescription drug or any part of a series or  
17 course of treatments.~~

~~18 "Complaint." A dispute or objection regarding a  
19 participating health care provider or the coverage, operations  
20 or management policies of [a managed care plan] an insurer, MCO  
21 or contractor, which has not been resolved by the [managed care  
22 plan] insurer, MCO or contractor and has been filed with the  
23 [plan] insurer, MCO or contractor or with the Department of  
24 Health or the Insurance Department of the Commonwealth. The term  
25 does not include a grievance.~~

~~26 "Complete prior authorization request." A request for prior  
27 authorization that meets an insurer's, MCO's or contractor's  
28 administrative policy requirements for such a request and that  
29 includes the specific clinical information necessary only to  
30 evaluate the request under the terms of the applicable medical~~

1 ~~policy. To the extent a health care provider network agreement~~  
2 ~~requires medical records to be transmitted electronically, or a~~  
3 ~~health care provider is capable of transmitting medical records~~  
4 ~~electronically to support a complete prior authorization request~~  
5 ~~for a health care service, the health care provider shall ensure~~  
6 ~~the insurer, MCO or contractor has electronic access to,~~  
7 ~~including the ability to print, the medical records that have~~  
8 ~~been transmitted electronically, subject to any applicable law~~  
9 ~~and the health care provider's corporate policies. The inability~~  
10 ~~of a health care provider to provide such access shall not~~  
11 ~~constitute a reason to deny an authorization request.~~

12 \* \* \*

13 ~~"Contractor." An insurer awarded a contract under section~~  
14 ~~2304 A to provide health care services. The term includes an~~  
15 ~~entity and an entity's subsidiary which is established under~~  
16 ~~this act, the act of December 29, 1972 (P.L.1701, No.364), known~~  
17 ~~as the Health Maintenance Organization Act or 40 Pa.C.S. Ch. 61~~  
18 ~~(relating to hospital plan corporation) or 63 (relating to~~  
19 ~~professional health services plan corporations).~~

20 \* \* \*

21 ~~"Drug formulary." A listing of [managed care plan] insurer,~~  
22 ~~MCO or contractor preferred therapeutic drugs.~~

23 \* \* \*

24 ~~"Enrollee." Any policyholder, subscriber, covered person or~~  
25 ~~other individual who is entitled to receive health care services~~  
26 ~~under a [managed care plan] health insurance policy, MCO~~  
27 ~~contract or CHIP contract.~~

28 ~~"Grievance." As provided in subdivision (i), a request by an~~  
29 ~~enrollee or a health care provider, with the written consent of~~  
30 ~~the enrollee, to have [a managed care plan] an insurer, MCO,~~

1 ~~contractor~~ or utilization review entity reconsider a decision  
2 solely concerning the medical necessity [and] ~~appropriateness,~~  
3 ~~health care setting, level of care or effectiveness of a health-~~  
4 ~~care service. If the [managed care plan] insurer, MCO or~~  
5 ~~contractor~~ is unable to resolve the matter, a grievance may be  
6 filed regarding the decision that:

7 (1) ~~disapproves full or partial payment for a requested~~  
8 ~~health care service;~~

9 (2) ~~approves the provision of a requested health care~~  
10 ~~service for a lesser scope or duration than requested; or~~

11 (3) ~~disapproves payment for the provision of a requested~~  
12 ~~health care service but approves payment for the provision of an~~  
13 ~~alternative health care service.~~

14 The term does not include a complaint.

15 \* \* \*

16 "Health care service." ~~Any covered treatment, admission,~~  
17 ~~procedure, medical supplies and equipment or other services,~~  
18 ~~including behavioral health, prescribed or otherwise provided or~~  
19 ~~proposed to be provided by a health care provider to an enrollee~~  
20 ~~[under a managed care plan contract.]~~

21 "Health insurance policy." ~~A policy, subscriber contract,~~  
22 ~~certificate or plan issued by an insurer that provides medical~~  
23 ~~or health care coverage. The term does not include any of the~~  
24 ~~following:~~

25 ~~(1) An accident only policy.~~

26 ~~(2) A credit only policy.~~

27 ~~(3) A long term care or disability income policy.~~

28 ~~(4) A specified disease policy.~~

29 ~~(5) A Medicare supplement policy.~~

30 ~~(6) A TRICARE policy, including a Civilian Health and~~

1 ~~Medical Program of the Uniformed Services (CHAMPUS) supplement~~  
2 ~~policy.~~

3 ~~(7) A fixed indemnity policy.~~

4 ~~(8) A hospital indemnity policy.~~

5 ~~(9) A dental only policy.~~

6 ~~(10) A vision only policy.~~

7 ~~(11) A workers' compensation policy.~~

8 ~~(12) An automobile medical payment policy.~~

9 ~~(13) A homeowners' insurance policy.~~

10 ~~(14) A short term limited duration policy.~~

11 ~~(15) Any other similar policy providing for limited~~  
12 ~~benefits.~~

13 ~~"Inpatient admission." Admission to a facility for purposes~~  
14 ~~of receiving a health care service at the inpatient level of~~  
15 ~~care.~~

16 ~~"Insurer." An entity licensed by the department to issue a~~  
17 ~~health insurance policy, subscriber contract, certificate or~~  
18 ~~plan that provides medical or health care coverage that is~~  
19 ~~offered or governed under any of the following:~~

20 ~~(1) Article XXIV, section 630 or any other provision of this~~  
21 ~~act.~~

22 ~~(2) A provision of 40 Pa.C.S. Ch. 61 or 63.~~

23 \* \* \*

24 ~~"MCO contract." The agreement between a medical assistance~~  
25 ~~managed care organization or MCO and the Department of Human~~  
26 ~~Services to provide for services to a Medicaid enrollee.~~

27 ~~"Medical assistance managed care organization" or "MCO." A~~  
28 ~~Medicaid managed care organization as defined in section 1903(m)~~

29 ~~(1) (A) of the Social Security Act (49 Stat. 620, 42 U.S.C. §~~  
30 ~~1396b(m) (1) (A)) that is a party to a Medicaid managed care~~

1 ~~contract with the Department of Human Services. The term does~~  
2 ~~not include a behavioral health managed care organization that~~  
3 ~~is a party to a Medicaid managed care contract with the~~  
4 ~~Department of Human Services.~~

5 ~~"Medical policy." A written document formally adopted,~~  
6 ~~maintained and applied by an insurer, MCO or contractor that~~  
7 ~~combines the clinical coverage criteria and any additional~~  
8 ~~administrative requirements, as applicable, necessary to~~  
9 ~~articulate the insurer's, MCO's or contractor's standards for~~  
10 ~~coverage of a given service or set of services under the terms~~  
11 ~~of a health insurance policy, MCO contract or CHIP contract.~~

12 ~~"Medical or scientific evidence." Evidence found in any of~~  
13 ~~the following sources:~~

14 ~~(1) A peer reviewed scientific study published in or~~  
15 ~~accepted for publication by a medical journal that meets~~  
16 ~~nationally recognized requirements for scientific manuscripts~~  
17 ~~and which journal submits most of its published articles for~~  
18 ~~review by experts who are not part of the journal's editorial~~  
19 ~~staff.~~

20 ~~(2) Peer reviewed medical literature, including literature~~  
21 ~~relating to a therapy reviewed and approved by a qualified~~  
22 ~~institutional review board, biomedical compendia and other~~  
23 ~~medical literature that meet the criteria of the National~~  
24 ~~Institutes of Health's Library of Medicine for indexing in Index~~  
25 ~~Medicus (Medline) and Elsevier Science Limited for indexing in~~  
26 ~~Excerpta Medica (EMBASE).~~

27 ~~(3) A medical journal recognized by the Secretary of Health~~  
28 ~~and Human Services under section 1861(t)(2) of the Social~~  
29 ~~Security Act (49 Stat. 620, 42 U.S.C. § 1395x(t)(2)).~~

30 ~~(4) One of the following standard reference compendia:~~



1 ~~(i) The American Hospital Formulary Service Drug~~  
2 ~~Information.~~

3 ~~(ii) Drug Facts and Comparison.~~

4 ~~(iii) The American Dental Association Accepted Dental~~  
5 ~~Therapeutics.~~

6 ~~(iv) The United States Pharmacopoeia Drug Information.~~

7 ~~(5) Findings, studies or research conducted by or under the~~  
8 ~~auspices of a Federal Government agency or nationally recognized~~  
9 ~~Federal research institute, including:~~

10 ~~(i) The Federal Agency for Healthcare Research and Quality.~~

11 ~~(ii) The National Institute of Health.~~

12 ~~(iii) The National Cancer Institute.~~

13 ~~(iv) The National Academy of Sciences.~~

14 ~~(v) The Centers for Medicare and Medicaid Services.~~

15 ~~(vi) The Food and Drug Administration.~~

16 ~~(vii) Any national board recognized by the National~~  
17 ~~Institutes of Health for the purpose of evaluating the medical~~  
18 ~~value of health care services.~~

19 ~~(6) Other medical or scientific evidence that is comparable~~  
20 ~~to the sources specified in paragraphs (1), (2), (3), (4) and~~  
21 ~~(5).~~

22 ~~"Medication assisted treatment." United States Food and Drug~~  
23 ~~Administration approved prescription drugs used in combination~~  
24 ~~with counseling and behavioral health therapies in the treatment~~  
25 ~~of opioid use disorders.~~

26 ~~"Nationally recognized medical standards." Clinical~~  
27 ~~criteria, practice guidelines and related standards established~~  
28 ~~by national quality and accreditation entities generally~~  
29 ~~recognized in the United States health care industry.~~

30 ~~"Participating provider." A health care provider that has~~

1 ~~entered into a contractual or operating relationship with an~~  
2 ~~insurer, MCO or contractor to participate in one or more~~  
3 ~~designated networks of the insurer, MCO or contractor and to~~  
4 ~~provide health care services to enrollees under the terms of the~~  
5 ~~insurer's, MCO's or contractor's administrative policy.~~

6 \* \* \*

7 ~~"Prior authorization." A review by an insurer, MCO,~~  
8 ~~contractor or by a utilization review entity acting on behalf of~~  
9 ~~an insurer, MCO or contractor of all reasonably necessary~~  
10 ~~supporting information that occurs prior to the delivery or~~  
11 ~~provision of a health care service and results in a decision to~~  
12 ~~approve or deny payment for the health care service. The term~~  
13 ~~includes step therapy and associated exceptions for prescription~~  
14 ~~drugs.~~

15 {~~"Prospective utilization review." A review by a utilization~~  
16 ~~review entity of all reasonably necessary supporting information~~  
17 ~~that occurs prior to the delivery or provision of a health care~~  
18 ~~service and results in a decision to approve or deny payment for~~  
19 ~~the health care service.}~~

20 ~~"Provider network." The health care providers designated by~~  
21 ~~{a managed care plan} an insurer, MCO or contractor to provide~~  
22 ~~health care services.~~

23 ~~"Provider portal." A designated section or functional~~  
24 ~~software module accessible via an insurer's, MCO's or~~  
25 ~~contractor's publicly accessible Internet website that~~  
26 ~~facilitates health care provider submission of electronic prior~~  
27 ~~authorization requests.~~

28 \* \* \*

29 ~~"Retrospective utilization review." A review by [a] an~~  
30 ~~insurer, MCO, contractor or utilization review entity acting on~~

1 ~~behalf of an insurer, MCO or contractor of all reasonably-~~  
2 ~~necessary supporting information which occurs following delivery-~~  
3 ~~or provision of a health care service and results in a decision-~~  
4 ~~to approve or deny payment for the health care service.~~

5 \* \* \*

6 ~~"Step therapy." A course of treatment where certain-~~  
7 ~~designated drugs or treatment protocols must be either-~~  
8 ~~contraindicated or used and found to be ineffective prior to-~~  
9 ~~approval of coverage for other designated drugs. The term does-~~  
10 ~~not include requests for coverage of nonformulary drugs.~~

11 ~~"Urgent health care service." A covered health care service-~~  
12 ~~subject to prior authorization that is delivered on an expedited-~~  
13 ~~basis for the treatment of an acute condition with symptoms of-~~  
14 ~~sufficient severity pursuant to a determination by a duly-~~  
15 ~~licensed and board certified treating physician, operating-~~  
16 ~~within the individual's scope of practice and professional-~~  
17 ~~expertise, that the absence of such significant medical-~~  
18 ~~intervention is likely to result in serious, long term health-~~  
19 ~~complications or a material deterioration in the enrollee's-~~  
20 ~~condition and prognosis.~~

21 ~~"Utilization review." A system of [prospective, concurrent]-~~  
22 ~~prior authorization, concurrent utilization review or-~~  
23 ~~retrospective utilization review performed by [a] an insurer,-~~  
24 ~~MCO, contractor or utilization review entity on behalf of an-~~  
25 ~~insurer, MCO or contractor of the medical necessity [and],-~~  
26 ~~appropriateness, health care setting and level of care or-~~  
27 ~~effectiveness of health care services prescribed, provided or-~~  
28 ~~proposed to be provided to an enrollee. The term does not-~~  
29 ~~include any of the following:~~

30 (1) ~~Requests for clarification of coverage, eligibility or-~~

1 ~~health care service verification.~~

2 ~~(2) A health care provider's internal quality assurance or~~  
3 ~~utilization review process unless the review results in denial~~  
4 ~~of payment for a health care service.~~

5 ~~"Utilization review entity." Any entity certified pursuant~~  
6 ~~to subdivision (h) that performs utilization review on behalf of~~  
7 ~~[a managed care plan] an insurer, MCO or contractor.~~

8 ~~Section 2. Subarticle (b) heading of Article XXI and~~  
9 ~~sections 2111, 2112 and 2113 of the act are amended to read:~~

10 ~~(b) [Managed Care Plan] Insurer, MCO and Contractor~~  
11 ~~Requirements.~~

12 ~~Section 2111. Responsibilities of [Managed Care Plans]~~  
13 ~~Insurer, MCOs and Contractors. [A managed care plan] An~~  
14 ~~insurer, MCO or contractor shall do all of the following:~~

15 ~~(1) Assure availability and accessibility of adequate health~~  
16 ~~care providers in a timely manner, which enables enrollees to~~  
17 ~~have access to quality care and continuity of health care~~  
18 ~~services.~~

19 ~~(2) Consult with health care providers in active clinical~~  
20 ~~practice regarding professional qualifications and necessary~~  
21 ~~specialists to be included in the [plan] health insurance~~  
22 ~~policy, MCO contract or CHIP contract.~~

23 ~~(3) Adopt and maintain a definition of medical necessity~~  
24 ~~used by the [plan] health insurance policy, MCO contract or CHIP~~  
25 ~~contract in determining health care services.~~

26 ~~(4) Ensure that emergency services are provided twenty four~~  
27 ~~(24) hours a day, seven (7) days a week and provide reasonable~~  
28 ~~payment or reimbursement for emergency services.~~

29 ~~(5) Adopt and maintain procedures by which an enrollee can~~  
30 ~~obtain health care services outside the [plan's] health~~

1 ~~insurance policy's, MCO contract's or CHIP contract's service~~  
2 ~~area.~~

3 ~~(6) Adopt and maintain procedures by which an enrollee with~~  
4 ~~a life threatening, degenerative or disabling disease or~~  
5 ~~condition shall, upon request, receive an evaluation and, if the~~  
6 ~~[plan's] insurer's, MCO's or contractor's established standards~~  
7 ~~are met, be permitted to receive:~~

8 ~~(i) a standing referral to a specialist with clinical~~  
9 ~~expertise in treating the disease or condition; or~~

10 ~~(ii) the designation of a specialist to provide and~~  
11 ~~coordinate the enrollee's primary and specialty care.~~

12 ~~The referral to or designation of a specialist shall be pursuant~~  
13 ~~to a treatment plan approved by the [managed care plan] insurer,~~  
14 ~~MCO or contractor in consultation with the primary care~~  
15 ~~provider, the enrollee and, as appropriate, the specialist. When~~  
16 ~~possible, the specialist must be a health care provider~~  
17 ~~participating in the [plan] health insurance policy, MCO~~  
18 ~~contract or CHIP contract.~~

19 ~~(7) Provide direct access to obstetrical and gynecological~~  
20 ~~services by permitting an enrollee to select a health care~~  
21 ~~provider participating in the [plan] health insurance policy,~~  
22 ~~MCO contract or CHIP contract to obtain maternity and~~  
23 ~~gynecological care, including medically necessary and~~  
24 ~~appropriate follow up care and referrals for diagnostic testing~~  
25 ~~related to maternity and gynecological care, without prior~~  
26 ~~approval from a primary care provider. The health care services~~  
27 ~~shall be within the scope of practice of the selected health~~  
28 ~~care provider. The selected health care provider shall inform~~  
29 ~~the enrollee's primary care provider of all health care services~~  
30 ~~provided.~~

1       ~~(8) Adopt and maintain a complaint process as set forth in~~  
2 ~~subdivision (g).~~

3       ~~(9) Adopt and maintain a grievance process as set forth in~~  
4 ~~subdivision (i).~~

5       ~~(10) Adopt and maintain credentialing standards for health-~~  
6 ~~care providers as set forth in subdivision (d).~~

7       ~~(11) Ensure that there are participating health care~~  
8 ~~providers that are physically accessible to people with~~  
9 ~~disabilities and can communicate with individuals with sensory~~  
10 ~~disabilities in accordance with Title III of the Americans with~~  
11 ~~Disabilities Act of 1990 (Public Law 101 336, 42 U.S.C. § 12181~~  
12 ~~et seq.).~~

13       ~~(12) Provide a list of health care providers participating~~  
14 ~~in the [plan] health insurance policy, MCO contract or CHIP~~  
15 ~~contract to the department every two (2) years or as may~~  
16 ~~otherwise be required by the department. The list shall include~~  
17 ~~the extent to which [health care] participating providers [in~~  
18 ~~the plan] are accepting new enrollees.~~

19       ~~(13) Report to the department and the Insurance Department~~  
20 ~~in accordance with the requirements of this article. Such~~  
21 ~~information shall include the number, type and disposition of~~  
22 ~~all complaints and grievances filed with the [plan] insurer, MCO~~  
23 ~~or contractor.~~

24       ~~Section 2112. Financial Incentives Prohibition. No [managed~~  
25 ~~care plan] insurer, MCO or contractor shall use any financial~~  
26 ~~incentive that compensates a health care provider for providing~~  
27 ~~less than medically necessary and appropriate care to an~~  
28 ~~enrollee. Nothing in this section shall be deemed to prohibit [a~~  
29 ~~managed care plan] an insurer, MCO or contractor from using a~~  
30 ~~capitated payment arrangement or other risk sharing arrangement.~~

1 Section 2113. ~~Medical Gag Clause Prohibition.~~ (a) ~~No~~  
2 ~~[managed care plan] insurer, MCO or contractor~~ may penalize or  
3 restrict a health care provider from discussing:

4 (1) ~~the process that the [plan] insurer, MCO or contractor~~  
5 ~~or any entity contracting with the [plan] insurer, MCO or~~  
6 ~~contractor~~ uses or proposes to use to deny payment for a health  
7 care service;

8 (2) ~~medically necessary and appropriate care with or on~~  
9 ~~behalf of an enrollee, including information regarding the~~  
10 ~~nature of treatment; risks of treatment; alternative treatments;~~  
11 ~~or the availability of alternate therapies, consultation or~~  
12 ~~tests; or~~

13 (3) ~~the decision of any [managed care plan] insurer, MCO or~~  
14 ~~contractor~~ to deny payment for a health care service.

15 (b) ~~A provision to prohibit or restrict disclosure of~~  
16 ~~medically necessary and appropriate health care information~~  
17 ~~contained in a contract with a health care provider is contrary~~  
18 ~~to public policy and shall be void and unenforceable.~~

19 (c) ~~No [managed care plan] insurer, MCO or contractor~~ shall  
20 ~~terminate the employment of or a contract with a health care~~  
21 ~~provider for any of the following:~~

22 (1) ~~Advocating for medically necessary and appropriate~~  
23 ~~health care consistent with the degree of learning and skill~~  
24 ~~ordinarily possessed by a reputable health care provider~~  
25 ~~practicing according to the applicable legal standard of care.~~

26 (2) ~~Filing a grievance pursuant to the procedures set forth~~  
27 ~~in this article.~~

28 (3) ~~Protesting a decision, policy or practice that the~~  
29 ~~health care provider, consistent with the degree of learning and~~  
30 ~~skill ordinarily possessed by a reputable health care provider~~

1 ~~practicing according to the applicable legal standard of care,~~  
2 ~~reasonably believes interferes with the health care provider's~~  
3 ~~ability to provide medically necessary and appropriate health~~  
4 ~~care.~~

5 ~~(d) Nothing in this section shall:~~

6 ~~(1) Prohibit [a managed care plan] an insurer, MCO or~~  
7 ~~contractor from making a determination not to pay for a~~  
8 ~~particular medical treatment, supply or service, enforcing~~  
9 ~~reasonable peer review or utilization review protocols or making~~  
10 ~~a determination that a health care provider has or has not~~  
11 ~~complied with appropriate protocols.~~

12 ~~(2) Be construed as requiring [a managed care plan] an~~  
13 ~~insurer, MCO or contractor to provide, reimburse for or cover~~  
14 ~~counseling, referral or other health care services if the [plan]~~  
15 ~~insurer, MCO or contractor:~~

16 ~~(i) objects to the provision of that service on moral or~~  
17 ~~religious grounds; and~~

18 ~~(ii) makes available information on its policies regarding~~  
19 ~~such health care services to enrollees and prospective~~  
20 ~~enrollees.~~

21 ~~Section 3. Section 2116(a) and (b) of the act are amended~~  
22 ~~and the section is amended by adding a subsection to read:~~

23 ~~Section 2116. Emergency Services. (a) If an enrollee seeks~~  
24 ~~emergency services and the emergency health care provider~~  
25 ~~determines that emergency services are necessary, the emergency~~  
26 ~~health care provider shall initiate necessary intervention to~~  
27 ~~evaluate and, if necessary, stabilize the condition of the~~  
28 ~~enrollee without seeking or receiving authorization from the~~  
29 ~~[managed care plan. The managed care plan] insurer, MCO or~~  
30 ~~contractor. No insurer, MCO or contractor shall require a health~~



~~1 care provider to submit a request for prior authorization for an  
2 emergency service. The insurer, MCO or contractor shall pay all  
3 reasonably necessary costs associated with emergency services  
4 provided during the period of emergency, subject to all  
5 copayments, coinsurances or deductibles[.], including testing  
6 and other diagnostic services that are medically necessary to  
7 evaluate or treat an emergency medical condition prior to the  
8 point at which the condition is stabilized. When processing a  
9 reimbursement claim for emergency services, [a managed care  
10 plan] an insurer, MCO or contractor shall consider both the  
11 presenting symptoms and the services provided. The [emergency]  
12 health care provider shall notify the enrollee's [managed care  
13 plan] insurer, MCO or contractor of the provision of emergency  
14 services and the condition of the enrollee. If an enrollee's  
15 condition has stabilized and the enrollee can be transported  
16 without suffering detrimental consequences or aggravating the  
17 enrollee's condition, the enrollee may be relocated to another  
18 facility to receive continued care and treatment as necessary.  
19 If an enrollee is admitted to inpatient care or placed in  
20 observation immediately following receipt of a covered emergency  
21 service, the inpatient facility shall have a minimum of twenty  
22 four (24) hours to notify the enrollee's insurer, MCO or  
23 contractor of the admission or placement with such timeframe to  
24 start at the later of:~~

25 (1) the time of the inpatient admission or placement; or  
26 (2) in the case of an enrollee that is unconscious, comatose  
27 or otherwise unable to effectively communicate pertinent  
28 information, the time at which the inpatient facility knew or  
29 reasonably should have known, through diligent efforts, the  
30 identity of the enrollee's insurer, MCO or contractor.

1       ~~(b) For emergency services rendered by a licensed emergency~~  
2 ~~medical services agency, as defined in 35 Pa.C.S. § 8103~~  
3 ~~(relating to definitions), that has the ability to transport~~  
4 ~~patients or is providing and billing for emergency services~~  
5 ~~under an agreement with an emergency medical services agency~~  
6 ~~that has that ability, the [managed care plan] insurer, MCO or~~  
7 ~~contractor may not deny a claim for payment solely because the~~  
8 ~~enrollee did not require transport or refused to be transported.~~

9       \* \* \*

10       ~~(c) Nothing in this section shall require an insurer, MCO or~~  
11 ~~contractor to waive application of otherwise applicable clinical~~  
12 ~~review criteria.~~

13       Section 4. Section 2117 of the act is amended to read:

14       Section 2117. Continuity of Care. (a) Except as provided  
15 under subsection (b), if [a managed care plan] ~~an insurer, MCO~~  
16 ~~or contractor~~ initiates termination of its contract with a  
17 participating health care provider, an enrollee may continue an  
18 ongoing course of treatment with that health care provider at  
19 the enrollee's option for a transitional period of up to sixty  
20 ~~(60) days from the date the enrollee was notified by the [plan]~~  
21 ~~insurer, MCO or contractor of the termination or pending~~  
22 ~~termination. The [managed care plan] insurer, MCO or contractor,~~  
23 ~~in consultation with the enrollee and the health care provider,~~  
24 ~~may extend the transitional period if determined to be~~  
25 ~~clinically appropriate. In the case of an enrollee in the second~~  
26 ~~or third trimester of pregnancy at the time of notice of the~~  
27 ~~termination or pending termination, the transitional period~~  
28 ~~shall extend through postpartum care related to the delivery.~~  
29 ~~Any health care service provided under this section shall be~~  
30 ~~covered by the [managed care plan] insurer, MCO or contractor~~

1 ~~under the same terms and conditions as applicable for~~  
2 ~~participating health care providers.~~

3 ~~(b) If the [plan] insurer, MCO or contractor terminates the~~  
4 ~~contract of a participating health care provider for cause,~~  
5 ~~including breach of contract, fraud, criminal activity or posing~~  
6 ~~a danger to an enrollee or the health, safety or welfare of the~~  
7 ~~public as determined by the [plan] insurer, MCO or contractor,~~  
8 ~~the [plan] insurer, MCO or contractor shall not be responsible~~  
9 ~~for health care services provided to the enrollee following the~~  
10 ~~date of termination.~~

11 ~~(c) If the [plan] insurer, MCO or contractor terminates the~~  
12 ~~contract of a participating primary care provider, the [plan]~~  
13 ~~insurer, MCO or contractor shall notify every enrollee served by~~  
14 ~~that provider of the [plan's] insurer's, MCO's or contractor's~~  
15 ~~termination of its contract and shall request that the enrollee~~  
16 ~~select another primary care provider.~~

17 ~~(d) A new enrollee may continue an ongoing course of~~  
18 ~~treatment with a nonparticipating health care provider for a~~  
19 ~~transitional period of up to sixty (60) days from the effective~~  
20 ~~date of enrollment in a [managed care plan] health insurance~~  
21 ~~policy, MCO contract or CHIP contract. The [managed care plan]~~  
22 ~~insurer, MCO or contractor, in consultation with the enrollee~~  
23 ~~and the health care provider, may extend this transitional~~  
24 ~~period if determined to be clinically appropriate. In the case~~  
25 ~~of a new enrollee in the second or third trimester of pregnancy~~  
26 ~~on the effective date of enrollment, the transitional period~~  
27 ~~shall extend through postpartum care related to the delivery.~~  
28 ~~Any health care service provided under this section shall be~~  
29 ~~covered by the [managed care plan] insurer, MCO or contractor~~  
30 ~~under the same terms and conditions as applicable for~~

1 ~~participating health care providers.~~

2 ~~(e) [A plan] An insurer, MCO or contractor may require a~~  
3 ~~nonparticipating health care provider whose health care services~~  
4 ~~are covered under this section to meet the same terms and~~  
5 ~~conditions as a participating health care provider.~~

6 ~~(f) Nothing in this section shall require [a managed care~~  
7 ~~plan] an insurer, MCO or contractor to provide health care~~  
8 ~~services that are not otherwise covered under the terms and~~  
9 ~~conditions of the [plan] health insurance policy, MCO contract~~  
10 ~~or CHIP contract.~~

11 ~~Section 5. The act is amended by adding a section to read:~~

12 ~~Section 2118. Medication assisted treatment. (a) An~~  
13 ~~insurer, MCO or contractor shall make available without initial~~  
14 ~~prior authorization coverage of at least one United States Food~~  
15 ~~and Drug Administration approved prescription drug classified as~~  
16 ~~Medication Assisted Treatment.~~

17 ~~(b) Nothing in this section shall prohibit an insurer, MCO~~  
18 ~~or contractor from designating preferred medications for the~~  
19 ~~relevant component of medication assisted treatment when~~  
20 ~~multiple medications are available, subject to applicable~~  
21 ~~requirements for documenting and posting any relevant medical~~  
22 ~~policy or prescription drug formulary information.~~

23 ~~(c) With the exception of prior authorization for initial~~  
24 ~~coverage, nothing in this section shall prohibit an insurer, MCO~~  
25 ~~or contractor from requiring prior authorization on subsequent~~  
26 ~~requests for medication assisted treatment to ensure adherence~~  
27 ~~with clinical guidelines.~~

28 ~~Section 6. Sections 2121, 2131 and 2136 of the act are~~  
29 ~~amended to read:~~

30 ~~Section 2121. Procedures. (a) [A managed care plan] An~~

1 ~~insurer, MCO or contractor shall establish a credentialing~~  
2 ~~process to enroll qualified health care providers and create an~~  
3 ~~adequate provider network. The process shall be approved by the~~  
4 ~~department and shall include written criteria and procedures for~~  
5 ~~initial enrollment, renewal, restrictions and termination of~~  
6 ~~credentials for health care providers.~~

7 (b) ~~The department shall establish credentialing standards~~  
8 ~~for [managed care plans.] insurers, MCOs and contractors. The~~  
9 ~~department may adopt nationally recognized accrediting standards~~  
10 ~~to establish the credentialing standards for [managed care~~  
11 ~~plans] insurers, MCOs and contractors.~~

12 (c) ~~[A managed care plan] An insurer, MCO or contractor~~  
13 ~~shall submit a report to the department regarding its~~  
14 ~~credentialing process at least every two (2) years or as may~~  
15 ~~otherwise be required by the department.~~

16 (d) ~~[A managed care plan] An insurer, MCO or contractor~~  
17 ~~shall disclose relevant credentialing criteria and procedures to~~  
18 ~~health care providers that apply to participate or that are~~  
19 ~~participating in the [plan's] insurer's, MCO's or contractor's~~  
20 ~~provider network. [A managed care plan] An insurer, MCO or~~  
21 ~~contractor shall also disclose relevant credentialing criteria~~  
22 ~~and procedures pursuant to a court order or rule. Any individual~~  
23 ~~providing information during the credentialing process of [a~~  
24 ~~managed care plan] an insurer, MCO or contractor shall have the~~  
25 ~~protections set forth in the act of July 20, 1974 (P.L.564,~~  
26 ~~No.193), known as the "Peer Review Protection Act."~~

27 (e) ~~No [managed care plan] insurer, MCO or contractor shall~~  
28 ~~exclude or terminate a health care provider from participation~~  
29 ~~in the [plan] health insurance policy, MCO contract or CHIP~~  
30 ~~contract due to any of the following:~~

1       ~~(1) The health care provider engaged in any of the~~  
2 ~~activities set forth in section 2113(c).~~

3       ~~(2) The health care provider has a practice that includes a~~  
4 ~~substantial number of patients with expensive medical~~  
5 ~~conditions.~~

6       ~~(3) The health care provider objects to the provision of or~~  
7 ~~refuses to provide a health care service on moral or religious~~  
8 ~~grounds.~~

9       ~~(f) If [a managed care plan] an insurer, MCO or contractor~~  
10 ~~denies enrollment or renewal of credentials to a health care~~  
11 ~~provider, the [managed care plan] insurer, MCO or contractor~~  
12 ~~shall provide the health care provider with written notice of~~  
13 ~~the decision. The notice shall include a clear rationale for the~~  
14 ~~decision.~~

15       ~~Section 2131. Confidentiality. (a) [A managed care plan]~~  
16 ~~An insurer, MCO, contractor and a utilization review entity~~  
17 ~~shall adopt and maintain procedures to ensure that all~~  
18 ~~identifiable information regarding enrollee health, diagnosis~~  
19 ~~and treatment is adequately protected and remains confidential~~  
20 ~~in compliance with all applicable Federal and State laws and~~  
21 ~~regulations and professional ethical standards.~~

22       ~~(b) To the extent [a managed care plan] an insurer, MCO or~~  
23 ~~contractor maintains medical records, the [plan] insurer, MCO or~~  
24 ~~contractor shall adopt and maintain procedures to ensure that~~  
25 ~~enrollees have timely access to their medical records unless~~  
26 ~~prohibited by Federal or State law or regulation.~~

27       ~~(c) (1) Information regarding an enrollee's health or~~  
28 ~~treatment shall be available to the enrollee, the enrollee's~~  
29 ~~designee or as necessary to prevent death or serious injury.~~

30       ~~(2) Nothing in this section shall:~~

1 ~~(i) Prevent disclosure necessary to determine coverage,~~  
2 ~~review complaints or grievances, conduct utilization review or~~  
3 ~~facilitate payment of a claim.~~

4 ~~(ii) Deny the department, the Insurance Department or the~~  
5 ~~Department of [Public Welfare] Human Services access to records~~  
6 ~~for purposes of quality assurance, investigation of complaints~~  
7 ~~or grievances, enforcement or other activities related to~~  
8 ~~compliance with this article and other laws of this~~  
9 ~~Commonwealth. Records shall be accessible only to department~~  
10 ~~employees or agents with direct responsibilities under the~~  
11 ~~provisions of this subparagraph.~~

12 ~~(iii) Deny access to information necessary for a utilization~~  
13 ~~review entity to conduct a review under this article.~~

14 ~~(iv) Deny access to the [managed care plan] insurer, MCO or~~  
15 ~~contractor for internal quality review, including reviews~~  
16 ~~conducted as part of the [plan's] insurer's, MCO's and~~  
17 ~~contractor's quality oversight process. During such reviews,~~  
18 ~~enrollees shall remain anonymous to the greatest extent~~  
19 ~~possible.~~

20 ~~(v) Deny access to [managed care plans] insurers, MCOs,~~  
21 ~~contractors, health care providers and their respective~~  
22 ~~designees for the purpose of providing patient care management,~~  
23 ~~outcomes improvement and research. For this purpose, enrollees~~  
24 ~~shall provide consent and shall remain anonymous to the greatest~~  
25 ~~extent possible.~~

26 ~~Section 2136. Required Disclosure. (a) [A managed care~~  
27 ~~plan] An insurer, MCO or contractor shall supply each enrollee~~  
28 ~~and, upon written request, each prospective enrollee or health~~  
29 ~~care provider with the following written information. Such~~  
30 ~~information shall be easily understandable by the layperson and~~

1 ~~shall include, but not be limited to:~~

2 ~~(1) A description of coverage, benefits and benefit~~  
3 ~~maximums, including benefit limitations and exclusions of~~  
4 ~~coverage, health care services and the definition of medical~~  
5 ~~necessity used by the [plan] health insurance, MCO contract or~~  
6 ~~CHIP contract in determining whether these benefits will be~~  
7 ~~covered. The following statement shall be included in all~~  
8 ~~marketing materials in boldface type:~~

9 ~~This [managed care plan] health insurance policy or contract~~  
10 ~~may not cover all your health care expenses. Read your~~  
11 ~~contract carefully to determine which health care services~~  
12 ~~are covered.~~

13 ~~The notice shall be followed by a telephone number to contact~~  
14 ~~the [plan] insurer, MCO or contractor.~~

15 ~~(2) A description of all necessary prior authorizations or~~  
16 ~~other requirements for nonemergency health care services as~~  
17 ~~required in section 2154(b).~~

18 ~~(3) An explanation of an enrollee's financial responsibility~~  
19 ~~for payment of premiums, coinsurance, copayments, deductibles~~  
20 ~~and other charges, annual limits on an enrollee's financial~~  
21 ~~responsibility and caps on payments for health care services~~  
22 ~~provided under the [plan] health insurance policy, MCO contract~~  
23 ~~or CHIP contract.~~

24 ~~(4) An explanation of an enrollee's financial responsibility~~  
25 ~~for payment when a health care service is provided by a~~  
26 ~~nonparticipating health care provider, when a health care~~  
27 ~~service is provided by any health care provider without required~~  
28 ~~authorization or when the care rendered is not covered by the~~  
29 ~~[plan] health insurance policy, MCO contract or CHIP contract.~~

30 ~~(5) A description of how the [managed care plan] insurer,~~



1 ~~MCO or contractor~~ addresses the needs of non-English speaking  
2 enrollees.

3 ~~(6) A notice of mailing addresses and telephone numbers~~  
4 ~~necessary to enable an enrollee to obtain approval or~~  
5 ~~authorization of a health care service or other information~~  
6 ~~regarding the [plan] health insurance policy, MCO contract or~~  
7 ~~CHIP contract.~~

8 ~~(7) A summary of the [plan's] health insurance policy's, MCO~~  
9 ~~contract's or CHIP contract's utilization review policies and~~  
10 ~~procedures.~~

11 ~~(8) A summary of all complaint and grievance procedures used~~  
12 ~~to resolve disputes between the [managed care plan] insurer, MCO~~  
13 ~~contractor and an enrollee or a health care provider, including:~~

14 ~~(i) The procedure to file a complaint or grievance as set~~  
15 ~~forth in this article, including a toll free telephone number to~~  
16 ~~obtain information regarding the filing and status of a~~  
17 ~~complaint or grievance.~~

18 ~~(ii) The right to appeal a decision relating to a complaint~~  
19 ~~or grievance.~~

20 ~~(iii) The enrollee's right to designate a representative to~~  
21 ~~participate in the complaint or grievance process as set forth~~  
22 ~~in this article.~~

23 ~~(iv) A notice that all disputes involving denial of payment~~  
24 ~~for a health care service will be made by qualified personnel~~  
25 ~~with experience in the same or similar scope of practice and~~  
26 ~~that all notices of decisions will include information regarding~~  
27 ~~the basis for the determination.~~

28 ~~(9) A description of the procedure for providing emergency~~  
29 ~~services twenty four (24) hours a day. The description shall~~  
30 ~~include:~~

1 ~~(i) A definition of emergency services as set forth in this~~  
2 ~~article.~~

3 ~~(ii) Notice that emergency services are not subject to prior~~  
4 ~~approval.~~

5 ~~(iii) The enrollee's financial and other responsibilities~~  
6 ~~regarding emergency services, including the receipt of these~~  
7 ~~services outside the [managed care plan's] insurer's, MCO's or~~  
8 ~~contractor's service area.~~

9 ~~(10) A description of the procedures for enrollees to select~~  
10 ~~a participating health care provider, including how to determine~~  
11 ~~whether a participating health care provider is accepting new~~  
12 ~~enrollees.~~

13 ~~(11) A description of the procedures for changing primary~~  
14 ~~care providers and specialists.~~

15 ~~(12) A description of the procedures by which an enrollee~~  
16 ~~may obtain a referral to a health care provider outside the~~  
17 ~~provider network when that provider network does not include a~~  
18 ~~health care provider with appropriate training and experience to~~  
19 ~~meet the health care service needs of an enrollee.~~

20 ~~(13) A description of the procedures that an enrollee with a~~  
21 ~~life threatening, degenerative or disabling disease or condition~~  
22 ~~shall follow and satisfy to be eligible for:~~

23 ~~(i) a standing referral to a specialist with clinical~~  
24 ~~expertise in treating the disease or condition; or~~

25 ~~(ii) the designation of a specialist to provide and~~  
26 ~~coordinate the enrollee's primary and specialty care.~~

27 ~~(14) A list by specialty of the name, address and telephone~~  
28 ~~number of all participating health care providers. The list may~~  
29 ~~be a separate document and shall be updated at least annually.~~

30 ~~(15) A list of the information available to enrollees or~~

1 ~~prospective enrollees, upon written request, under subsection~~  
2 ~~(b).~~

3 ~~(b) Each [managed care plan] insurer, MCO or contractor~~  
4 ~~shall, upon written request of an enrollee or prospective~~  
5 ~~enrollee, provide the following written information:~~

6 ~~(1) A list of the names, business addresses and official~~  
7 ~~positions of the membership of the board of directors or~~  
8 ~~officers of the [managed care plan] insurer, MCO or contractor.~~

9 ~~(2) The procedures adopted to protect the confidentiality of~~  
10 ~~medical records and other enrollee information.~~

11 ~~(3) A description of the credentialing process for health~~  
12 ~~care providers.~~

13 ~~(4) A list of the participating health care providers~~  
14 ~~affiliated with participating hospitals.~~

15 ~~(5) Whether a specifically identified drug is included or~~  
16 ~~excluded from coverage.~~

17 ~~(6) A description of the process by which a health care~~  
18 ~~provider can prescribe specific drugs, drugs used for an off-~~  
19 ~~label purpose, biologicals and medications not included in the~~  
20 ~~drug formulary for prescription drugs or biologicals when the~~  
21 ~~formulary's equivalent has been ineffective in the treatment of~~  
22 ~~the enrollee's disease or if the drug causes or is reasonably~~  
23 ~~expected to cause adverse or harmful reactions to the enrollee.~~

24 ~~(7) A description of the procedures followed by the [managed~~  
25 ~~care plan] insurer, MCO or contractor to make decisions about~~  
26 ~~the experimental nature of individual drugs, medical devices or~~  
27 ~~treatments.~~

28 ~~(8) A summary of the methodologies used by the [managed care~~  
29 ~~plan] insurer, MCO or contractor to reimburse for health care~~  
30 ~~services. Nothing in this paragraph shall be construed to~~

1 ~~require disclosure of individual contracts or the specific~~  
2 ~~details of any financial arrangement between [a managed care~~  
3 ~~plan] an insurer, MCO, contractor and a health care provider.~~

4 ~~(9) A description of the procedures used in the [managed~~  
5 ~~care plan's] insurer's, MCO's or contractor's quality assurance~~  
6 ~~program.~~

7 ~~(10) Other information as may be required by the department~~  
8 ~~or the Insurance Department.~~

9 ~~Section 7. The act is amended by adding a section to read:~~

10 ~~Section 2137. Medical policy and clinical review criteria~~  
11 ~~adopted by an insurer, MCO or contractor. (a) An insurer, MCO~~  
12 ~~or contractor shall make available its current medical policies~~  
13 ~~on the insurer's, MCO's and contractor's publicly accessible~~  
14 ~~Internet website or provider portal. The insurer's, MCO's or~~  
15 ~~contractor's medical policies shall include reference to the~~  
16 ~~clinical review criteria used in developing the medical policy.~~  
17 ~~If an insurer's, MCO's or contractor's medical policy~~  
18 ~~incorporates licensed third party standards that also limit the~~  
19 ~~insurer's, MCO's or contractor's ability to publish those~~  
20 ~~standards in full, the insurer's, MCO's or contractor's posted~~  
21 ~~policies shall clearly identify these sources.~~

22 ~~(b) An insurer, MCO or contractor shall review each adopted~~  
23 ~~medical policy on at least an annual basis.~~

24 ~~(c) An insurer, MCO or contractor shall notify health care~~  
25 ~~providers of discretionary changes to medical policies at least~~  
26 ~~thirty (30) days prior to application of the changes. The~~  
27 ~~following apply:~~

28 ~~(1) In the case of policy changes due to changes in Federal~~  
29 ~~or State law, regulation or binding agency guidance, an insurer,~~  
30 ~~MCO or contractor shall notify health care providers at least~~

~~1 thirty (30) days prior to the application of the changes, except  
2 that in cases where the timing of changes in binding guidance  
3 makes such advance notice impracticable, an insurer, MCO or  
4 contractor shall make commercially reasonable efforts to notify  
5 providers of such changes prior to their application.~~

~~6 (2) Notification of changes may be provided through the  
7 posting of an updated and dated medical policy reflecting the  
8 change or through other reasonable means.~~

~~9 (3) In the case of changes to medical policies that modify,  
10 eliminate or suspend either clinical or administrative criteria  
11 and that directly result in less restrictive coverage of a given  
12 service, an insurer, MCO or contractor shall notify health care  
13 providers within (30) days after application of such change.~~

~~14 (d) Clinical review criteria adopted by an insurer, MCO or  
15 contractor at the time of medical policy development or review  
16 shall:~~

~~17 (1) Be based on nationally recognized medical standards.~~

~~18 (2) Be consistent with applicable governmental guidelines.~~

~~19 (3) Provide for the delivery of a health care service in a  
20 clinically appropriate type, frequency, setting and duration.~~

~~21 (4) Reflect the current quality of medical and scientific  
22 evidence regarding emerging procedures, clinical guidelines and  
23 best practices as articulated in independent, peer reviewed  
24 medical literature.~~

~~25 (e) Nothing in this section shall require an insurer, MCO or  
26 contractor to provide coverage for a health care service that is  
27 otherwise excluded from coverage under a health insurance  
28 policy, MCO contract or CHIP contract.~~

~~29 Section 8. Sections 2141, 2142(a) and (b), 2143, 2151(e) and  
30 2152(a)(3), (4)(i) and (7) and (c) of the act are amended to~~

1 read:

2 Section 2141. Internal Complaint Process. (a) ~~[A managed~~  
3 ~~care plan] An insurer, MCO or contractor shall establish and~~  
4 ~~maintain an internal complaint process [with two levels of~~  
5 ~~review] by which an enrollee shall be able to file a complaint~~  
6 ~~[regarding a participating health care provider or the coverage,~~  
7 ~~operations or management policies of the managed care plan].~~

8 (b) ~~The complaint process shall consist of [an initial] a~~  
9 ~~review [to] by a committee of three or more individuals, a third~~  
10 ~~of which shall not be employed by the insurer, MCO or contractor~~  
11 ~~and shall include all of the following:~~

12 ~~{(1) A review by an initial review committee consisting of~~  
13 ~~one or more employees of the managed care plan.}~~

14 ~~(2) The allowance of a written or oral complaint.~~

15 ~~(3) The allowance of written data or other information.~~

16 ~~(4) A review or investigation of the complaint which shall~~  
17 ~~be completed within thirty (30) days of receipt of the~~  
18 ~~complaint.~~

19 ~~(5) A written notification to the enrollee regarding the~~  
20 ~~decision of the [initial] review committee within five (5)~~  
21 ~~business days of the decision. [Notice shall include the basis~~  
22 ~~for the decision and the procedure to file a request for a~~  
23 ~~second level review of the decision of the initial review~~  
24 ~~committee.~~

25 ~~(c) The complaint process shall include a second level~~  
26 ~~review that includes all of the following:~~

27 ~~(1) A review of the decision of the initial review committee~~  
28 ~~by a second level review committee consisting of three or more~~  
29 ~~individuals who did not participate in the initial review. At~~  
30 ~~least one third of the second level review committee shall not~~

1 ~~be employed by the managed care plan.~~

2 ~~(2) A written notification to the enrollee of the right to~~  
3 ~~appear before the second level review committee.~~

4 ~~(3) A requirement that the second level review be completed~~  
5 ~~within forty five (45) days of receipt of a request for such~~  
6 ~~review.~~

7 ~~(4) A written notification to the enrollee regarding the~~  
8 ~~decision of the second level review committee within five (5)~~  
9 ~~business days of the decision.] The notice shall include the~~  
10 ~~basis for the decision and the procedure for appealing the~~  
11 ~~decision to the department or the Insurance Department.~~

12 ~~Section 2142. Appeal of Complaint. (a) An enrollee shall~~  
13 ~~have [fifteen (15) days] four (4) months from receipt of the~~  
14 ~~notice of the decision from the [second level] review committee~~  
15 ~~to appeal the decision to the department or the Insurance~~  
16 ~~Department, as appropriate.~~

17 ~~(b) All records from the [initial] review [and second level~~  
18 ~~review] shall be transmitted to the appropriate department in~~  
19 ~~the manner prescribed. The enrollee, the health care provider or~~  
20 ~~the [managed care plan] insurer, MCO or contractor may submit~~  
21 ~~additional materials related to the complaint.~~

22 ~~\* \* \*~~

23 ~~Section 2143. Complaint Resolution. Nothing in this~~  
24 ~~subdivision shall prevent the department or the Insurance~~  
25 ~~Department from communicating with the enrollee, the health care~~  
26 ~~provider or the [managed care plan] insurer, MCO or contractor~~  
27 ~~as appropriate to assist in the resolution of a complaint. Such~~  
28 ~~communication may occur at any time during the complaint~~  
29 ~~process.~~

30 ~~Section 2151. Certification. \* \* \*~~

1       ~~(e) [A licensed] An insurer [or a managed care plan], MCO or~~  
2 ~~contractor with a certificate of authority shall comply with the~~  
3 ~~standards and procedures of this subdivision but shall not be~~  
4 ~~required to obtain separate certification as a utilization~~  
5 ~~review entity.~~

6       Section 2152. Operational Standards. ~~(a) A utilization~~  
7 ~~review entity shall do all of the following:~~

8       \* \* \*

9       ~~(3) Ensure that a health care provider is able to verify~~  
10 ~~that an individual requesting information on behalf of the~~  
11 ~~[managed care plan] insurer, MCO or contractor is a legitimate~~  
12 ~~representative of the [plan] insurer, MCO or contractor.~~

13       ~~(4) Conduct utilization reviews based on the medical~~  
14 ~~necessity [and], appropriateness, health care setting, level of~~  
15 ~~care or effectiveness of the health care service being reviewed~~  
16 ~~and provide notification within the following time frames:~~

17       ~~(i) A [prospective utilization review] prior authorization~~  
18 ~~decision shall be communicated [within two (2) business days of~~  
19 ~~the receipt of all supporting information reasonably necessary~~  
20 ~~to complete the review.] pursuant to the review timelines~~  
21 ~~contained in section 2154(g).~~

22       \* \* \*

23       ~~(7) Notify the health care provider of additional facts or~~  
24 ~~documents required to complete the utilization review within~~  
25 ~~forty eight (48) hours of receipt of the request for review[.]~~  
26 ~~or pursuant to section 2154(h) for missing clinical information~~  
27 ~~for all requests for prior authorization.~~

28       \* \* \*

29       ~~(c) Utilization review that results in a denial of payment~~  
30 ~~for a health care service, not including an administrative~~



1 ~~denial, shall be made by a licensed physician, except as~~  
2 ~~provided in subsection (d) or section 2154(c) for all requests~~  
3 ~~for prior authorization.~~

4 \* \* \*

5 Section 9. ~~The act is amended by adding sections to read:~~

6 ~~Section 2153. Step Therapy Considerations. The following:~~

7 ~~(1) If an insurer's, MCO's or contractor's medical policy~~  
8 ~~adopted under section 2137 incorporates step therapy criteria~~  
9 ~~for prescription drugs, an insurer, MCO or contractor shall~~  
10 ~~consider as part of the insurer's, MCO's or contractor's initial~~  
11 ~~prior authorization process or a request for an exception to the~~  
12 ~~insurer's, MCO's or contractors step therapy criteria, and based~~  
13 ~~on the enrollee's individualized clinical condition, the~~  
14 ~~following:~~

15 ~~(i) Contraindications, including adverse reactions.~~

16 ~~(ii) Clinical effectiveness or ineffectiveness of the~~  
17 ~~required prerequisite prescription drugs or therapies.~~

18 ~~(iii) Past clinical outcome of the required prerequisite~~  
19 ~~prescription drug or therapy.~~

20 ~~(iv) The expected clinical outcomes of the requested~~  
21 ~~prescription drug prescribed by the enrollee's health care~~  
22 ~~provider.~~

23 ~~(v) For new enrollees, whether the enrollee has already~~  
24 ~~satisfied a step therapy protocol with their previous health~~  
25 ~~insurer that required trials of drugs from each of the classes~~  
26 ~~that are required by the current insurer's, MCO's or~~  
27 ~~contractor's step therapy protocol.~~

28 ~~(2) The provisions of section 2154 shall apply to step~~  
29 ~~therapy reviews conducted under this section.~~

30 ~~Section 2154. Prior Authorization Review. (a) (1)~~

~~1 Insurer, MCO or contractor review of a request for prior  
2 authorization shall be based upon the insurer's, MCO's or  
3 contractor's medical policy, administrative policy and all  
4 medical information and evidence submitted by the requesting  
5 provider.~~

~~6 (2) At the time of review, an insurer, MCO or contractor  
7 shall also verify the enrollee's eligibility for coverage under  
8 the terms of the applicable health insurance policy, MCO  
9 contract or CHIP contract.~~

~~10 (3) Appeals of administrative denials shall be subject to  
11 the complaint process under subarticle (g).~~

~~12 (b) An insurer, MCO or contractor shall make available a  
13 list, posted in a publicly accessible format and location on the  
14 insurer's, MCO's or contractor's publicly accessible Internet  
15 website, and provider portal, that indicates the health services  
16 for which the insurer, MCO or contractor requires prior  
17 authorization.~~

~~18 (c) Other than an administrative denial, a request for prior  
19 authorization may only be denied upon review by a properly  
20 licensed medical professional with appropriate training,  
21 knowledge or experience in the same or similar specialty that  
22 typically manages or consults on the health care service in  
23 question. Alternatively, an insurer, MCO or contractor may  
24 satisfy this requirement through the completion of the review by  
25 a licensed medical professional in consultation with an  
26 appropriately qualified third party medical professional,  
27 licensed in the same or similar medical specialty as the  
28 requesting health care provider or type of health care provider  
29 that typically manages the enrollee's associated condition,  
30 provided that any compensation paid to the consulting~~

1 ~~professional may not be contingent upon the outcome of the~~  
2 ~~review. Nothing in this section shall compel an insurer, MCO or~~  
3 ~~contractor to obtain third party medical professionals in the~~  
4 ~~same specialty or subspecialty.~~

5 ~~(d) In the case of a denied prior authorization, the~~  
6 ~~insurer, MCO or contractor shall make available to the~~  
7 ~~requesting health care provider a licensed medical professional~~  
8 ~~for a peer to peer review discussion. The peer to peer reviewer~~  
9 ~~provided by the insurer, MCO or contractor shall meet the~~  
10 ~~standards under subsection (c) and have authority to modify or~~  
11 ~~overturn the prior authorization decision. The procedure for~~  
12 ~~requesting a peer to peer review shall be available on the~~  
13 ~~insurer's, MCO's or contractor's publicly accessible Internet~~  
14 ~~website and provider portal. An insurer's, MCO's or contractor's~~  
15 ~~peer to peer procedure shall include, but not be limited to,~~  
16 ~~ability to request a peer to peer discussion:~~

17 ~~(1) during normal business hours; or~~  
18 ~~(2) outside normal business hours subject to reasonable~~  
19 ~~limitations on the availability of qualified insurer, MCO or~~  
20 ~~contractor staff. In the event an insurer, MCO or contractor~~  
21 ~~uses a third party vendor or utilization review entity to~~  
22 ~~conduct peer to peer reviews for denials administered by the~~  
23 ~~vendor or entity, the procedure under subsection (i) shall~~  
24 ~~include contact information and information on the hours of~~  
25 ~~availability of the vendor or entity necessary for a requesting~~  
26 ~~health care provider to schedule a peer to peer discussion.~~

27 ~~(e) A health care provider may designate, and an insurer,~~  
28 ~~MCO or contractor shall accept, another licensed member of the~~  
29 ~~health care provider's affiliated or employed clinical staff~~  
30 ~~with knowledge of the enrollee's condition and requested~~

~~1 procedure as a qualified proxy for purposes of completing a  
2 peer to peer discussion. Individuals eligible to receive a proxy  
3 designation shall be limited to licensed health care providers  
4 whose actual authority and scope of practice is inclusive of  
5 performing or prescribing the requested health care service.  
6 Such authority may be established through a supervising  
7 physician consistent with applicable State law for non physician  
8 practitioners. The insurer, MCO or contractor must accept and  
9 review the information submitted by other members of a health  
10 care provider's affiliated or employed staff in support of a  
11 prior authorization request. The insurer, MCO or contractor may  
12 not limit interactions with an insurer's, MCO's or contractor's  
13 clinical staff solely to the requesting health care provider.~~

~~14 (f) A peer to peer discussion shall be available to a  
15 requesting health care provider from the time of a denial of  
16 prior authorization until the internal grievance process  
17 commences. If a peer to peer discussion is available prior to  
18 adjudicating a prior authorization request, the peer to peer  
19 shall be offered within the timeline in subsection (g).~~

~~20 (g) An insurer's, MCO's or contractor's decision to approve  
21 or deny prior authorization shall be rendered within the  
22 following timeframes and following the submission of a complete  
23 prior authorization request:~~

~~24 (1) An insurer, MCO or contractor shall issue a prior  
25 authorization determination for a medical health care service in  
26 accordance with the following timeframes:~~

~~27 (i) Review of request for urgent health care services as  
28 expeditiously as the enrollee's health condition requires but no  
29 more than seventy two (72) hours.~~

~~30 (ii) Review of request for non urgent medical services not~~

1 ~~more than fifteen (15) calendar days.~~

2 ~~(2) Insurers, MCOs and contractors shall issue a prior~~  
3 ~~authorization determination for a prescription drug medication~~  
4 ~~or render a decision on step therapy under section 2153 in~~  
5 ~~accordance with the following timeframes:~~

6 ~~(i) Review or urgent request not more than twenty four (24)~~  
7 ~~hours.~~

8 ~~(ii) Review of standard request not more than two (2)~~  
9 ~~business days and not to exceed seventy two (72) hours.~~

10 ~~(3) If at any time after requesting prior authorization the~~  
11 ~~health care provider determines the enrollee's medical condition~~  
12 ~~requires emergency services, such services may be provided under~~  
13 ~~section 2116.~~

14 ~~(4) Upon receipt of a submission of a prior authorization~~  
15 ~~request, an insurer, MCO or contractor shall notify the health~~  
16 ~~care provider of any missing or other supporting information~~  
17 ~~necessary to make it a complete prior authorization request in~~  
18 ~~accordance with subsection (h).~~

19 ~~(h) In the event that a prior authorization request is~~  
20 ~~missing clinical information that is reasonably necessary to~~  
21 ~~complete a review, the insurer, MCO or contractor shall notify~~  
22 ~~the health care provider of any missing clinical information~~  
23 ~~necessary to complete the review within twenty four (24) hours~~  
24 ~~of receipt of the prior authorization request for urgent health~~  
25 ~~care services or within two (2) business days of receipt of all~~  
26 ~~other types of prior authorization requests and allow the~~  
27 ~~requesting health care provider or any member of the requesting~~  
28 ~~health care provider's clinical or administrative staff to~~  
29 ~~submit such information within the established review time~~  
30 ~~lines. A request for information under this subsection shall be~~

1 ~~made with sufficient specificity to enable the health care~~  
2 ~~provider to identify the necessary clinical or other supporting~~  
3 ~~information necessary to complete review.~~

4 ~~(i) An insurer, MCO or contractor may supplement submitted~~  
5 ~~information based on current clinical records or other current~~  
6 ~~medical information for an enrollee as available, provided that~~  
7 ~~the supplemental information is also made available to the~~  
8 ~~enrollee or health care provider as part of the enrollee's~~  
9 ~~authorization case file upon request. In response to any request~~  
10 ~~for missing information, an insurer, MCO or contractor shall~~  
11 ~~also accept supplemental information from any member of the~~  
12 ~~health care provider's clinical staff.~~

13 ~~(j) If a health care provider performs a closely related~~  
14 ~~service, the insurer, MCO or contractor may not deny a claim for~~  
15 ~~the closely related service for failure of the health care~~  
16 ~~provider to seek or obtain prior authorization, provided that:~~

17 ~~(1) The health care provider notifies the insurer, MCO or~~  
18 ~~contractor of the performance of the closely related service no~~  
19 ~~later than seventy two (72) hours following completion of the~~  
20 ~~service but prior to the submission of the claim for~~  
21 ~~payment. The submission of the notification shall include the~~  
22 ~~submission of all relevant clinical information necessary for~~  
23 ~~the insurer, MCO or contractor to evaluate the medical necessity~~  
24 ~~and appropriateness of the service.~~

25 ~~(2) Nothing in this subsection shall be construed to limit~~  
26 ~~an insurer's, MCO's or contractor's consideration of medical~~  
27 ~~necessity and appropriateness of the closely service, nor limit~~  
28 ~~the need for verification of the enrollee's eligibility for~~  
29 ~~coverage.~~

30 ~~Section 2155. Provider portal. (a) Within eighteen (18)~~

~~1 months following the effective date of this section, an insurer,  
2 MCO or contractor shall establish a provider portal that  
3 includes, at minimum, the following features:~~

~~4 (1) Electronic submission of prior authorization requests.~~

~~5 (2) Access to an insurer's, MCO's or contractor's applicable  
6 medical policies.~~

~~7 (3) Information necessary to request a peer to peer review.~~

~~8 (4) Contact information for an insurer's, MCO's or  
9 contractor's relevant clinical or administrative staff.~~

~~10 (5) For any prior authorization service not subject to  
11 electronic submission via the provider portal, copies of any  
12 applicable submission forms.~~

~~13 (6) Instructions for the submission of prior authorization  
14 requests in the event that an insurer's, MCO's or contractor's  
15 provider portal is unavailable for any reason.~~

~~16 (b) Within six (6) months following the establishment of  
17 provider portals under subsection (a), an insurer, MCO or  
18 contractor shall make available to health care providers and  
19 their affiliated or employed staff access to training on the use  
20 of the insurer's, MCO's or contractor's provider portal.~~

~~21 (c) Within eighteen (18) months following the establishment  
22 of provider portals under subsection (a), a health care provider  
23 seeking prior authorization shall submit such request via an  
24 insurer's, MCO's or contractor's provider portal, provided that:~~

~~25 (1) Submission via provider portal shall only be required to  
26 the extent an insurer's, MCO's or contractor's provider portal  
27 is available and operational at the time of attempted  
28 submission.~~

~~29 (2) Submission via an insurer's, MCO's or contractor's  
30 provider portal shall only be required to the extent the health-~~

1 ~~care provider has access to the insurer's, MCO's or contractor's~~  
2 ~~operational provider portal.~~

3 ~~(3) Insurers, MCOs and contractors may elect to maintain~~  
4 ~~allowances for submission of prior authorization requests~~  
5 ~~outside of the provider portal.~~

6 Section 10. Sections 2161, 2162, 2163, 2166, subarticle (k)  
7 heading of Article XXI and sections 2171, 2181, 2182 and 2191 of  
8 the act are amended to read:

9 Section 2161. Internal Grievance Process. (a) ~~[A managed~~  
10 ~~care plan] An insurer, MCO or contractor shall establish and~~  
11 ~~maintain an internal grievance process [with two levels of~~  
12 ~~review] and an expedited internal grievance process by which an~~  
13 ~~enrollee or a health care provider, with the written consent of~~  
14 ~~the enrollee, shall be able to file a written grievance~~  
15 ~~regarding the denial of payment for a health care service within~~  
16 ~~four (4) months of receiving an adverse benefit determination.~~  
17 ~~An enrollee who consents to the filing of a grievance by a~~  
18 ~~health care provider under this section may not file a separate~~  
19 ~~grievance.~~

20 (b) ~~The internal grievance process shall consist of [an~~  
21 ~~initial] a review that includes all of the following:~~

22 (1) ~~A review by [one] three or more persons selected by the~~  
23 ~~[managed care plan] insurer, MCO or contractor who did not~~  
24 ~~previously participate in the decision to deny payment for the~~  
25 ~~health care service.~~

26 (2) ~~The completion of the review within thirty (30) days of~~  
27 ~~receipt of the grievance.~~

28 (3) ~~A written notification to the enrollee and health care~~  
29 ~~provider[.] of the right to appear before the review committee~~  
30 ~~within five (5) business days of receiving the internal~~



1 ~~grievance.~~

2 ~~(4) A written notification to the enrollee and health care~~  
3 ~~provider regarding the decision within five (5) business days of~~  
4 ~~the decision. The notice shall include the basis and clinical~~  
5 ~~rationale for the decision and the procedure to file a request~~  
6 ~~[for a second level review of] appealing the decision as an~~  
7 ~~external grievance.~~

8 ~~[(c) The grievance process shall include a second level~~  
9 ~~review that includes all of the following:~~

10 ~~(1) A review of the decision issued pursuant to subsection~~  
11 ~~(b) by a second level review committee consisting of three or~~  
12 ~~more persons who did not previously participate in any decision~~  
13 ~~to deny payment for the health care service.~~

14 ~~(2) A written notification to the enrollee or the health~~  
15 ~~care provider of the right to appear before the second level~~  
16 ~~review committee.~~

17 ~~(3) The completion of the second level review within forty~~  
18 ~~five (45) days of receipt of a request for such review.~~

19 ~~(4) A written notification to the enrollee and health care~~  
20 ~~provider regarding the decision of the second level review~~  
21 ~~committee within five (5) business days of the decision. The~~  
22 ~~notice shall include the basis and clinical rationale for the~~  
23 ~~decision and the procedure for appealing the decision.]~~

24 ~~(d) Any [initial review or second level] review conducted~~  
25 ~~under this section shall include a licensed physician, or, where~~  
26 ~~appropriate, an approved licensed psychologist, in the same or~~  
27 ~~similar specialty that typically manages or consults on the~~  
28 ~~health care service.~~

29 ~~(e) Should the enrollee's life, health or ability to regain~~  
30 ~~maximum function be in jeopardy, an expedited internal grievance~~

1 ~~process shall be available which shall include a requirement~~  
2 ~~that a decision with appropriate notification to the enrollee~~  
3 ~~and health care provider be made within forty eight (48) hours~~  
4 ~~of the filing of the expedited grievance.~~

5 ~~Section 2162. External Grievance Process. (a) [A managed~~  
6 ~~care plan] An insurer, MCO or contractor shall establish and~~  
7 ~~maintain an external grievance process by which an enrollee or a~~  
8 ~~health care provider with the written consent of the enrollee~~  
9 ~~may appeal the denial of a grievance following completion of the~~  
10 ~~internal grievance process. The external grievance process shall~~  
11 ~~be conducted by an independent utilization review entity not~~  
12 ~~directly affiliated with the [managed care plan] insurer, MCO or~~  
13 ~~contractor.~~

14 ~~(b) To conduct external grievances filed under this section:~~

15 ~~(1) The department shall randomly assign a utilization~~  
16 ~~review entity on a rotational basis from the list maintained~~  
17 ~~under subsection (d) and notify the assigned utilization review~~  
18 ~~entity and the [managed care plan] insurer, MCO or contractor~~  
19 ~~within two (2) business days of receiving the request. If the~~  
20 ~~department fails to select a utilization review entity under~~  
21 ~~this subsection, the [managed care plan] insurer, MCO or~~  
22 ~~contractor shall designate and notify a certified utilization~~  
23 ~~review entity to conduct the external grievance.~~

24 ~~(2) The [managed care plan] insurer, MCO or contractor shall~~  
25 ~~notify the enrollee or health care provider of the name, address~~  
26 ~~and telephone number of the utilization review entity assigned~~  
27 ~~under this subsection within two (2) business days.~~

28 ~~(c) The external grievance process shall meet all of the~~  
29 ~~following requirements:~~

30 ~~(1) Any external grievance shall be filed with the [managed~~

1 ~~care plan] insurer, MCO or contractor within [fifteen (15) days]~~  
2 ~~four (4) months of receipt of a notice of denial resulting from~~  
3 ~~the internal grievance process. The filing of the external~~  
4 ~~grievance shall include any material justification and all~~  
5 ~~reasonably necessary supporting information. Within five (5)~~  
6 ~~business days of the filing of an external grievance, the~~  
7 ~~[managed care plan] insurer, MCO or contractor shall notify the~~  
8 ~~enrollee or the health care provider, the utilization review~~  
9 ~~entity that conducted the internal grievance and the department~~  
10 ~~that an external grievance has been filed.~~

11 ~~(2) The utilization review entity that conducted the~~  
12 ~~internal grievance shall forward copies of all written~~  
13 ~~documentation regarding the denial, including the decision, all~~  
14 ~~reasonably necessary supporting information, a summary of~~  
15 ~~applicable issues and the basis and clinical rationale for the~~  
16 ~~decision, to the utilization review entity conducting the~~  
17 ~~external grievance within fifteen (15) days of receipt of notice~~  
18 ~~that the external grievance was filed. Any additional written~~  
19 ~~information may be submitted by the enrollee or the health care~~  
20 ~~provider within fifteen (15) days of receipt of notice that the~~  
21 ~~external grievance was filed.~~

22 ~~(3) The utilization review entity conducting the external~~  
23 ~~grievance shall review all information considered in reaching~~  
24 ~~any prior decisions to deny payment for the health care service~~  
25 ~~and any other written submission by the enrollee or the health~~  
26 ~~care provider.~~

27 ~~(4) An external grievance decision shall be made by:~~

28 ~~(i) one or more licensed physicians or approved licensed~~  
29 ~~psychologists in active clinical practice or in the same or~~  
30 ~~similar specialty that typically manages or recommends treatment~~

1 ~~for the health care service being reviewed; or~~

2 ~~(ii) one or more physicians currently certified by a board~~  
3 ~~approved by the American Board of Medical Specialists or the~~  
4 ~~American Board of Osteopathic Specialties in the same or similar~~  
5 ~~specialty that typically manages or recommends treatment for the~~  
6 ~~health care service being reviewed.~~

7 ~~(5) Within sixty (60) days of the filing of the external~~  
8 ~~grievance, the utilization review entity conducting the external~~  
9 ~~grievance shall issue a written decision to the [managed care~~  
10 ~~plan] insurer, MCO or contractor, the enrollee and the health~~  
11 ~~care provider, including the basis and clinical rationale for~~  
12 ~~the decision. The standard of review shall be whether the health~~  
13 ~~care service denied by the internal grievance process was~~  
14 ~~medically necessary and appropriate under the terms of the~~  
15 ~~[plan] health insurance policy, MCO contract or CHIP contract.~~

16 ~~The external grievance decision shall be subject to appeal to a~~  
17 ~~court of competent jurisdiction within sixty (60) days of~~  
18 ~~receipt of notice of the external grievance decision. There~~  
19 ~~shall be a rebuttable presumption in favor of the decision of~~  
20 ~~the utilization review entity conducting the external grievance.~~

21 ~~(6) The [managed care plan] insurer, MCO or contractor shall~~  
22 ~~authorize any health care service or pay a claim determined to~~  
23 ~~be medically necessary and appropriate under paragraph (5)~~  
24 ~~pursuant to section 2166 whether or not an appeal to a court of~~  
25 ~~competent jurisdiction has been filed.~~

26 ~~(7) All fees and costs related to an external grievance~~  
27 ~~shall be paid by the nonprevailing party if the external~~  
28 ~~grievance was filed by the health care provider. The health care~~  
29 ~~provider and the utilization review entity or [managed care~~  
30 ~~plan] insurer, MCO or contractor shall each place in escrow an~~

1 amount equal to one half of the estimated costs of the external  
2 grievance process. If the external grievance was filed by the  
3 enrollee, all fees and costs related thereto shall be paid by  
4 the ~~[managed care plan] insurer, MCO or contractor~~. For purposes  
5 of this paragraph, fees and costs shall not include attorney  
6 fees.

7 (d) ~~The department shall compile and maintain a list of~~  
8 ~~certified utilization review entities that meet the requirements~~  
9 ~~of this article. The department may remove a utilization review~~  
10 ~~entity from the list if such an entity is incapable of~~  
11 ~~performing its responsibilities in a reasonable manner, charges~~  
12 ~~excessive fees or violates this article.~~

13 (e) ~~A fee may be imposed by [a managed care plan] an~~  
14 ~~insurer, MCO or contractor for filing an external grievance~~  
15 ~~pursuant to this article which shall not exceed twenty five~~  
16 ~~(\$25) dollars.~~

17 (f) ~~Written contracts between [managed care plans] insurers,~~  
18 ~~MCO or contractor and health care providers may provide an~~  
19 ~~alternative dispute resolution system to the external grievance~~  
20 ~~process set forth in this article if the department approves the~~  
21 ~~contract. The alternative dispute resolution system shall be~~  
22 ~~impartial, include specific time limitations to initiate~~  
23 ~~appeals, receive written information, conduct hearings and~~  
24 ~~render decisions and otherwise satisfy the requirements of this~~  
25 ~~section. A written decision pursuant to an alternative dispute~~  
26 ~~resolution system shall be final and binding on all parties. An~~  
27 ~~alternative dispute resolution system shall not be utilized for~~  
28 ~~any external grievance filed by an enrollee.~~

29 Section 2163. Records. ~~Records regarding grievances filed~~  
30 ~~under this subdivision that result in decisions adverse to~~

1 ~~enrollees shall be maintained by the [plan] insurer, MCO or~~  
2 ~~contractor for not less than three (3) years. These records~~  
3 ~~shall be provided to the department, if requested, in accordance~~  
4 ~~with section 2131(c)(2)(ii).~~

5 ~~Section 2166. Prompt Payment of Claims. (a) [A licensed]~~  
6 ~~An insurer [or a managed care plan], MCO or contractor shall pay~~  
7 ~~a clean claim submitted by a health care provider within forty~~  
8 ~~five (45) days of receipt of the clean claim.~~

9 ~~(b) If [a licensed] an insurer [or a managed care plan], MCO~~  
10 ~~or contractor fails to remit the payment as provided under~~  
11 ~~subsection (a), interest at ten per centum (10%) per annum shall~~  
12 ~~be added to the amount owed on the clean claim. Interest shall~~  
13 ~~be calculated beginning the day after the required payment date~~  
14 ~~and ending on the date the claim is paid. The licensed insurer~~  
15 ~~or [managed care plan] insurer, MCO or contractor shall not be~~  
16 ~~required to pay any interest calculated to be less than two (\$2)~~  
17 ~~dollars.~~

18 ~~(k) Health Care Provider [and Managed Care Plan], Insurer, MCO~~  
19 ~~and Contractor Protection.~~

20 ~~Section 2171. Health Care Provider [and Managed Care Plan],~~  
21 ~~Insurer, MCO and Contractor Protection. (a) [A managed care~~  
22 ~~plan] An insurer, MCO or contractor shall not exclude,~~  
23 ~~discriminate against or penalize any health care provider for~~  
24 ~~its refusal to allow, perform, participate in or refer for~~  
25 ~~health care services when the refusal of the health care~~  
26 ~~provider is based on moral or religious grounds and that~~  
27 ~~provider makes adequate information available to enrollees or,~~  
28 ~~if applicable, prospective enrollees.~~

29 ~~(b) No public institution, public official or public agency~~  
30 ~~may take disciplinary action against, deny licensure or~~

~~1 certification or penalize any person, association or corporation  
2 attempting to establish a [plan] health insurance policy, MCO  
3 contract, CHIP contract or operating, expanding or improving an  
4 existing [plan] health insurance policy, MCO contract or CHIP  
5 contract because the person, association or corporation refuses  
6 to provide any particular form of health care services or other  
7 services or supplies covered by other [plans] health insurance  
8 policies, MCO contracts or CHIP contracts when the refusal is  
9 based on moral or religious grounds.~~

~~10 Section 2181. Departmental Powers and Duties. (a) The  
11 department shall require that records and documents submitted to  
12 [a managed care plan] an insurer, MCO, contractor or utilization  
13 review entity as part of any complaint or grievance be made  
14 available to the department, upon request, for purposes of  
15 enforcement or compliance with this article.~~

~~16 (b) The department shall compile data received from [a  
17 managed care plan] an insurer, MCO or contractor on an annual  
18 basis regarding the number, type and disposition of complaints  
19 and grievances filed with [a managed care plan] an insurer, MCO  
20 or contractor under this article.~~

~~21 (c) The department shall issue guidelines identifying those  
22 provisions of this article that exceed or are not included in  
23 the "Standards for the Accreditation of Managed Care  
24 Organizations" published by the National Committee for Quality  
25 Assurance. These guidelines shall be published in the  
26 Pennsylvania Bulletin and updated as necessary. Copies of the  
27 guidelines shall be made available to [managed care plans]  
28 insurers, MCOs, contractors, health care providers and enrollees  
29 upon request.~~

~~30 (d) The department and the Insurance Department shall ensure~~

1 ~~compliance with this article. The appropriate department shall~~  
2 ~~investigate potential violations of the article based upon~~  
3 ~~information received from enrollees, health care providers and~~  
4 ~~other sources in order to ensure compliance with this article.~~

5 ~~(e) The department and the Insurance Department shall~~  
6 ~~promulgate such regulations as may be necessary to carry out the~~  
7 ~~provisions of this article.~~

8 ~~(f) The department in cooperation with the Insurance~~  
9 ~~Department shall submit an annual report to the General Assembly~~  
10 ~~regarding the implementation, operation and enforcement of this~~  
11 ~~article.~~

12 ~~Section 2182. Penalties and Sanctions. (a) The department~~  
13 ~~or the Insurance Department, as appropriate, may impose a civil~~  
14 ~~penalty of up to five thousand (\$5,000) dollars for a violation~~  
15 ~~of this article.~~

16 ~~(b) [A managed care plan] An insurer, MCO or contractor~~  
17 ~~shall be subject to the act of July 22, 1974 (P.L.589, No.205),~~  
18 ~~known as the "Unfair Insurance Practices Act."~~

19 ~~(c) The department or the Insurance Department may maintain~~  
20 ~~an action in the name of the Commonwealth for an injunction to~~  
21 ~~prohibit any activity which violates the provisions of this~~  
22 ~~article.~~

23 ~~(d) The department may issue an order temporarily~~  
24 ~~prohibiting [a managed care plan] an insurer, MCO or contractor~~  
25 ~~which violates this article from enrolling new members.~~

26 ~~(e) The department may require [a managed care plan] an~~  
27 ~~insurer, MCO or contractor to develop and adhere to a plan of~~  
28 ~~correction approved by the department. The department shall~~  
29 ~~monitor compliance with the plan of correction. The plan of~~  
30 ~~correction shall be available to enrollees of the [managed care~~



1 ~~plan] insurer, MCO or contractor upon request.~~

2 ~~(f) In no event shall the department and the Insurance~~  
3 ~~Department impose a penalty for the same violation.~~

4 ~~Section 2191. Compliance with National Accrediting~~  
5 ~~Standards. Notwithstanding any other provision of this article~~  
6 ~~to the contrary, the department shall give consideration to [a~~  
7 ~~managed care plan's] an insurer's, MCO's or contractor's~~  
8 ~~demonstrated compliance with the standards and requirements set~~  
9 ~~forth in the "Standards for the Accreditation of Managed Care~~  
10 ~~Organizations" published by the National Committee for Quality~~  
11 ~~Assurance or other department approved quality review~~  
12 ~~organizations in determining compliance with the same or similar~~  
13 ~~provisions of this article. The [managed care plan] insurer, MCO~~  
14 ~~or contractor, however, shall remain subject to and shall comply~~  
15 ~~with any other provisions of this article that exceed or are not~~  
16 ~~included in the standards of the National Committee for Quality~~  
17 ~~Assurance or other department approved quality review~~  
18 ~~organizations.~~

19 ~~Section 11. This act shall take effect as follows:~~

20 ~~(1) This section shall take effect immediately.~~

21 ~~(2) The addition of section 2155 of the act shall take~~  
22 ~~effect January 1, 2023.~~

23 ~~(3) The remainder of this act shall take effect January~~  
24 ~~1, 2024.~~

25 SECTION 1. SECTION 2102, SUBDIVISION (B) HEADING OF ARTICLE <--  
26 XXI, SECTIONS 2111, 2112, 2113, 2116, 2117, 2121 AND 2131,  
27 SUBDIVISION (F) HEADING OF ARTICLE XXI AND SECTION 2136 OF THE  
28 ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE  
29 COMPANY LAW OF 1921, ARE AMENDED TO READ:

30 SECTION 2102. DEFINITIONS.--AS USED IN THIS ARTICLE, THE

1 FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO  
2 THEM IN THIS SECTION:

3 "ACTIVE CLINICAL PRACTICE." THE PRACTICE OF CLINICAL  
4 MEDICINE BY A HEALTH CARE PROVIDER FOR AN AVERAGE OF NOT LESS  
5 THAN TWENTY (20) HOURS PER WEEK.

6 "ADMINISTRATIVE DENIAL." AN ADVERSE BENEFIT DETERMINATION OF  
7 PRIOR AUTHORIZATION, COVERAGE OR PAYMENT BASED ON A LACK OF  
8 ELIGIBILITY, FAILURE TO SUBMIT COMPLETE INFORMATION OR OTHER  
9 FAILURE TO COMPLY WITH AN ADMINISTRATIVE POLICY. THE TERM DOES  
10 NOT INCLUDE AN ADVERSE BENEFIT DETERMINATION BASED ON MEDICAL <--  
11 NECESSITY SUBJECT TO THE EXTERNAL REVIEW PROCESS AS SET FORTH IN <--  
12 SECTION 2164.1(A).

13 "ADMINISTRATIVE POLICY." A WRITTEN DOCUMENT OR COLLECTION OF  
14 DOCUMENTS REFLECTING THE TERMS OF THE CONTRACTUAL OR OPERATING  
15 RELATIONSHIP BETWEEN AN INSURER OR MA OR CHIP MANAGED CARE PLAN  
16 AND A HEALTH CARE PROVIDER.

17 "ADVERSE BENEFIT DETERMINATION." AN ADVERSE BENEFIT  
18 DETERMINATION MAY BE ANY OF THE FOLLOWING:

19 (1) A DETERMINATION BY AN INSURER OR A UTILIZATION REVIEW  
20 ENTITY ON BEHALF OF AN INSURER THAT, BASED UPON THE INFORMATION  
21 PROVIDED AND UPON APPLICATION OF UTILIZATION REVIEW, A REQUEST  
22 FOR A BENEFIT UNDER A HEALTH INSURANCE POLICY DOES NOT MEET THE  
23 INSURER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS,  
24 HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OR IS  
25 DETERMINED TO BE EXPERIMENTAL OR INVESTIGATIONAL, SUCH THAT THE  
26 REQUESTED BENEFIT IS THEREFORE DENIED, REDUCED OR TERMINATED OR  
27 PAYMENT IS NOT PROVIDED OR MADE, IN WHOLE OR IN PART, FOR THE  
28 BENEFIT.

29 (2) THE DENIAL, REDUCTION, TERMINATION OR FAILURE TO PROVIDE  
30 OR MAKE PAYMENT, IN WHOLE OR IN PART, FOR A BENEFIT BASED ON A

1 DETERMINATION BY AN INSURER OF A PERSON'S ELIGIBILITY FOR  
2 COVERAGE UNDER A HEALTH INSURANCE POLICY OR NONCOMPLIANCE WITH  
3 AN ADMINISTRATIVE POLICY.

4 (3) A RESCISSION OF COVERAGE DETERMINATION BY AN INSURER. <--  
5 "AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES." A- <--  
6 CONTRACT AN AGREEMENT BETWEEN AN MA OR CHIP MANAGED CARE PLAN <--  
7 AND THE DEPARTMENT OF HUMAN SERVICES OR PRIMARY CONTRACTOR OF <--  
8 THE DEPARTMENT OF HUMAN SERVICES TO MANAGE THE PURCHASE AND  
9 PROVISION OF MEDICAL, BEHAVIORAL HEALTH OR HOME AND COMMUNITY <--  
10 BASED SERVICES. THE TERM INCLUDES A COUNTY OR MULTICOUNTY <--  
11 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES FOR BEHAVIORAL  
12 HEALTH SERVICES.

13 ["ANCILLARY SERVICE PLANS." ANY INDIVIDUAL OR GROUP HEALTH  
14 INSURANCE PLAN, SUBSCRIBER CONTRACT OR CERTIFICATE THAT PROVIDES  
15 EXCLUSIVE COVERAGE FOR DENTAL SERVICES OR VISION SERVICES. THE  
16 TERM ALSO INCLUDES MEDICARE SUPPLEMENT POLICIES SUBJECT TO  
17 SECTION 1882 OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C.  
18 § 1395SS) AND THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE  
19 UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT.] <--

20 "APPLICABLE GOVERNMENTAL GUIDELINES." CLINICAL PRACTICE AND  
21 ASSOCIATED GUIDELINES ISSUED UNDER THE AUTHORITY OF THE UNITED  
22 STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES  
23 FOOD AND DRUG ADMINISTRATION, CENTERS FOR DISEASE CONTROL AND  
24 PREVENTION, PENNSYLVANIA DEPARTMENT OF HEALTH OR OTHER SIMILARLY  
25 SITUATED FEDERAL OR STATE AGENCY, DEPARTMENT OR SUBUNIT THEREOF  
26 FOCUSED ON THE PROVISION OR REGULATION OF MEDICAL CARE,  
27 PRESCRIPTION DRUGS OR PUBLIC HEALTH WITHIN THE UNITED STATES OR <--  
28 THIS COMMONWEALTH.

29 "AUTHORIZED REPRESENTATIVE." ONE OF THE FOLLOWING:

30 (1) A PERSON, INCLUDING A HEALTH CARE PROVIDER, TO WHOM A

1 COVERED PERSON OR ENROLLEE HAS GIVEN EXPRESS WRITTEN CONSENT TO  
2 REPRESENT THE COVERED PERSON OR ENROLLEE IN A COMPLAINT,  
3 GRIEVANCE, ADVERSE BENEFIT DETERMINATION, INTERNAL APPEAL OR  
4 EXTERNAL REVIEW PROCESS.

5 (2) A PERSON AUTHORIZED BY LAW TO PROVIDE SUBSTITUTED  
6 CONSENT FOR A COVERED PERSON OR ENROLLEE.

7 (3) A FAMILY MEMBER OR TREATING HEALTH CARE PROVIDER  
8 INVOLVED IN PROVIDING HEALTH CARE TO A COVERED PERSON OR  
9 ENROLLEE IF THE COVERED PERSON OR ENROLLEE IS INCAPACITATED OR  
10 UNAVAILABLE UNABLE TO PROVIDE CONSENT DUE TO A MEDICAL EMERGENCY <--  
11 OR AS NECESSARY TO PREVENT A SERIOUS AND IMMINENT THREAT TO THE <--  
12 HEALTH OR SAFETY OF THE COVERED PERSON OR ENROLLEE.

13 "CLEAN CLAIM." A CLAIM FOR PAYMENT FOR A HEALTH CARE SERVICE  
14 WHICH HAS NO DEFECT OR IMPROPRIETY. A DEFECT OR IMPROPRIETY  
15 SHALL INCLUDE LACK OF REQUIRED SUBSTANTIATING DOCUMENTATION OR A  
16 PARTICULAR CIRCUMSTANCE REQUIRING SPECIAL TREATMENT WHICH  
17 PREVENTS TIMELY PAYMENT FROM BEING MADE ON THE CLAIM. THE TERM  
18 SHALL NOT INCLUDE A CLAIM FROM A HEALTH CARE PROVIDER WHO IS  
19 UNDER INVESTIGATION FOR FRAUD OR ABUSE REGARDING THAT CLAIM.

20 "CLINICAL REVIEW CRITERIA." THE SET OF WRITTEN SCREENING  
21 PROCEDURES, DECISION ABSTRACTS, CLINICAL PROTOCOLS AND PRACTICE  
22 GUIDELINES USED BY AN INSURER OR MA OR CHIP MANAGED CARE PLAN TO  
23 DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE  
24 SERVICES.

25 "CLOSELY-RELATED SERVICE." A HEALTH CARE SERVICE SUBJECT TO  
26 PRIOR AUTHORIZATION THAT IS CLOSELY RELATED IN PURPOSE,  
27 DIAGNOSTIC UTILITY OR DESIGNATED HEALTH CARE BILLING CODE, AND  
28 PROVIDED ON THE SAME DATE OF SERVICE AS AN AUTHORIZED SERVICE,  
29 SUCH THAT A PRUDENT HEALTH CARE PROVIDER, ACTING WITHIN THE  
30 SCOPE OF THE PROVIDER'S LICENSE AND EXPERTISE, MAY REASONABLY BE

1 EXPECTED TO PERFORM THE SERVICE IN CONJUNCTION WITH OR IN LIEU  
2 OF THE ORIGINALLY AUTHORIZED SERVICE IN RESPONSE TO MINOR  
3 DIFFERENCES IN OBSERVED PATIENT CHARACTERISTICS OR NEEDS FOR  
4 DIAGNOSTIC INFORMATION THAT WERE NOT READILY IDENTIFIABLE UNTIL  
5 THE PROVIDER WAS ACTUALLY PERFORMING THE ORIGINALLY AUTHORIZED  
6 SERVICE. THE TERM DOES NOT INCLUDE AN ORDER FOR OR  
7 ADMINISTRATION OF A PRESCRIPTION DRUG OR ANY PART OF A SERIES OR  
8 COURSE OF TREATMENTS.

9 "COMMISSIONER." THE INSURANCE COMMISSIONER OF THE  
10 COMMONWEALTH.

11 "COMPLAINT." A DISPUTE OR OBJECTION REGARDING A  
12 PARTICIPATING HEALTH CARE PROVIDER OR THE COVERAGE, OPERATIONS  
13 OR MANAGEMENT POLICIES OF [A] AN INSURER OR MA OR CHIP MANAGED  
14 CARE PLAN WHICH HAS NOT BEEN RESOLVED BY THE INSURER OR MA OR  
15 CHIP MANAGED CARE PLAN AND HAS BEEN FILED WITH THE INSURER, MA  
16 OR CHIP MANAGED CARE PLAN OR [WITH THE DEPARTMENT OF HEALTH OR  
17 THE INSURANCE DEPARTMENT OF THE COMMONWEALTH] DEPARTMENT. THE  
18 TERM DOES NOT INCLUDE A GRIEVANCE OR AN ADVERSE BENEFIT  
19 DETERMINATION ELIGIBLE FOR EXTERNAL REVIEW. <--

20 "CONCURRENT [UTILIZATION] REVIEW." A REVIEW [BY A  
21 UTILIZATION REVIEW ENTITY] PERFORMED BY AN INSURER OR MA OR CHIP  
22 MANAGED CARE PLAN, OR BY A UTILIZATION REVIEW ENTITY ACTING ON  
23 BEHALF OF AN INSURER OR MA OR CHIP MANAGED CARE PLAN OF ALL  
24 REASONABLY NECESSARY SUPPORTING INFORMATION WHICH OCCURS DURING  
25 A COVERED PERSON'S OR AN ENROLLEE'S HOSPITAL STAY OR COURSE OF <--  
26 TREATMENT AND RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT  
27 FOR THE HEALTH CARE SERVICE.

28 "COVERED BENEFIT." A HEALTH CARE SERVICE AS SET FORTH IN THE  
29 TERMS OF A HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE  
30 DEPARTMENT OF HUMAN SERVICES. THE TERM INCLUDES A COVERED <--

1 SERVICE.

2 "COVERED PERSON." A POLICYHOLDER, SUBSCRIBER OR OTHER  
3 INDIVIDUAL WHO IS ENTITLED TO RECEIVE HEALTH CARE SERVICES UNDER  
4 A HEALTH INSURANCE POLICY.

5 ~~"COVERED SERVICE." A HEALTH CARE SERVICE ELIGIBLE FOR~~ <--  
6 ~~PAYMENT UNDER THE TERMS OF A HEALTH INSURANCE POLICY OR AN~~  
7 ~~AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.~~

8 "DEPARTMENT." THE [DEPARTMENT OF HEALTH] INSURANCE  
9 DEPARTMENT OF THE COMMONWEALTH.

10 ["DISCHARGE PLANNING." THE FORMAL PROCESS FOR DETERMINING, <--  
11 PRIOR TO DISCHARGE FROM A FACILITY, THE COORDINATION AND  
12 MANAGEMENT OF CARE THAT A COVERED PERSON OR ENROLLEE WILL  
13 RECEIVE FOLLOWING THE DISCHARGE.]

14 "DISCHARGE PLANNING." THE FORMAL PROCESS FOR DETERMINING, <--  
15 PRIOR TO DISCHARGE FROM A FACILITY, THE COORDINATION AND  
16 MANAGEMENT OF CARE THAT A COVERED PERSON OR ENROLLEE WILL  
17 RECEIVE FOLLOWING THE DISCHARGE.

18 "DRUG FORMULARY." A LISTING OF HEALTH INSURANCE POLICY OR MA  
19 OR CHIP MANAGED CARE PLAN PREFERRED THERAPEUTIC DRUGS.

20 "EMERGENCY SERVICE." [ANY] A HEALTH CARE SERVICE PROVIDED TO  
21 [AN] A COVERED PERSON OR ENROLLEE AFTER THE SUDDEN ONSET OF A  
22 MEDICAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF  
23 SUFFICIENT SEVERITY OR SEVERE PAIN SUCH THAT A PRUDENT LAYPERSON  
24 WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD  
25 REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO  
26 RESULT IN:

27 (1) PLACING THE HEALTH OF THE COVERED PERSON OR ENROLLEE IN  
28 SERIOUS JEOPARDY OR, WITH RESPECT TO A PREGNANT WOMAN, THE  
29 HEALTH OF THE WOMAN OR HER UNBORN CHILD IN SERIOUS JEOPARDY;

30 (2) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

1 (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.  
2 ~~EMERGENCY TRANSPORTATION [AND] OR RELATED EMERGENCY SERVICE~~ <--  
3 PROVIDED BY A LICENSED AMBULANCE SERVICE SHALL CONSTITUTE AN  
4 EMERGENCY SERVICE.] ~~THE TERM INCLUDES EMERGENCY TRANSPORTATION~~ <--  
5 ~~AND RELATED EMERGENCY SERVICES PROVIDED BY A LICENSED AMBULANCE~~  
6 ~~SERVICE.~~

7 "ENROLLEE." [ANY POLICYHOLDER, SUBSCRIBER, COVERED PERSON OR  
8 OTHER INDIVIDUAL] AN INDIVIDUAL WHO IS ENTITLED TO RECEIVE  
9 HEALTH CARE SERVICES UNDER [A MANAGED CARE PLAN] AN AGREEMENT  
10 WITH THE DEPARTMENT OF HUMAN SERVICES.

11 "EVIDENCE-BASED STANDARD." INTERVENTIONS AND TREATMENT  
12 APPROACHES THAT HAVE BEEN PROVEN EFFECTIVE THROUGH APPROPRIATE  
13 EMPIRICAL ANALYSIS.

14 "FACILITY." A HEALTH CARE SETTING OR INSTITUTION PROVIDING  
15 HEALTH CARE SERVICES, INCLUDING:

16 (1) A GENERAL, SPECIAL, PSYCHIATRIC OR REHABILITATION  
17 HOSPITAL.

18 (2) AN AMBULATORY SURGICAL FACILITY.

19 (3) A CANCER TREATMENT CENTER.

20 (4) A BIRTH CENTER.

21 (5) A SKILLED NURSING CENTER.

22 (6) AN INPATIENT, OUTPATIENT OR RESIDENTIAL DRUG AND ALCOHOL  
23 TREATMENT FACILITY.

24 (7) A FACILITY LICENSED BY THE DEPARTMENT OF HUMAN SERVICES' <--  
25 OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

26 ~~(7)~~ (8) A LABORATORY, IMAGING, DIAGNOSTIC OR OTHER <--  
27 OUTPATIENT MEDICAL SERVICE OR TESTING FACILITY.

28 ~~(8)~~ (9) A HEALTH CARE PROVIDER OFFICE OR CLINIC. <--

29 "FINAL ADVERSE BENEFIT DETERMINATION." AN ADVERSE BENEFIT  
30 DETERMINATION THAT HAS BEEN UPHeld BY AN INSURER OR A

1 UTILIZATION REVIEW ENTITY DESIGNATED BY THE INSURER AT THE  
2 COMPLETION OF THE INSURER'S INTERNAL CLAIM AND APPEAL PROCEDURES  
3 AS SPECIFIED IN SECTION ~~2161.1~~ 2164. <--

4 "GRIEVANCE." [AS PROVIDED IN SUBDIVISION (I), A] A REQUEST  
5 TO AN MA OR CHIP MANAGED CARE PLAN BY AN ENROLLEE OR [A HEALTH  
6 CARE PROVIDER, WITH THE WRITTEN CONSENT OF THE ENROLLEE,] AN  
7 ENROLLEE'S AUTHORIZED REPRESENTATIVE TO HAVE [A] AN MA OR CHIP  
8 MANAGED CARE PLAN [OR UTILIZATION REVIEW ENTITY] RECONSIDER A  
9 DECISION SOLELY CONCERNING THE MEDICAL NECESSITY [AND],  
10 APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR  
11 EFFECTIVENESS OF A HEALTH CARE SERVICE. IF THE MA OR CHIP  
12 MANAGED CARE PLAN IS UNABLE TO RESOLVE THE MATTER, A GRIEVANCE  
13 MAY BE FILED REGARDING THE DECISION THAT:

14 (1) DISAPPROVES FULL OR PARTIAL PAYMENT FOR A REQUESTED  
15 HEALTH CARE SERVICE;

16 (2) APPROVES THE PROVISION OF A REQUESTED HEALTH CARE  
17 SERVICE FOR A LESSER SCOPE OR DURATION THAN REQUESTED; OR

18 (3) DISAPPROVES PAYMENT FOR THE PROVISION OF A REQUESTED  
19 HEALTH CARE SERVICE BUT APPROVES PAYMENT FOR THE PROVISION OF AN  
20 ALTERNATIVE HEALTH CARE SERVICE.

21 THE TERM DOES NOT INCLUDE A COMPLAINT OR AN ADVERSE BENEFIT  
22 DETERMINATION.

23 "HEALTH CARE PROVIDER." A LICENSED HOSPITAL OR HEALTH CARE  
24 FACILITY, MEDICAL EQUIPMENT SUPPLIER OR PERSON WHO IS LICENSED,  
25 CERTIFIED OR OTHERWISE REGULATED TO PROVIDE HEALTH CARE SERVICES  
26 UNDER THE LAWS OF THIS COMMONWEALTH, INCLUDING A PHYSICIAN,  
27 PODIATRIST, OPTOMETRIST, PSYCHOLOGIST, PHYSICAL THERAPIST,  
28 CERTIFIED NURSE PRACTITIONER, REGISTERED NURSE, NURSE MIDWIFE,  
29 PHYSICIAN'S ASSISTANT, CHIROPRACTOR, DENTIST, PHARMACIST OR AN  
30 INDIVIDUAL ACCREDITED OR CERTIFIED TO PROVIDE BEHAVIORAL HEALTH



1 ~~SERVICES. FOR MA OR CHIP MANAGED CARE PLANS, THE TERM SHALL ALSO~~ <--  
2 ~~REFER TO AN INDIVIDUAL PROVIDING PERSONAL ASSISTANCE OR~~  
3 ~~REHABILITATIVE SERVICES. THE TERM INCLUDES AN INDIVIDUAL~~ <--  
4 ~~PROVIDING EMERGENCY SERVICES UNDER A LICENSED EMERGENCY MEDICAL~~  
5 ~~SERVICES AGENCY AS DEFINED IN 35 PA.C.S. § 8103 (RELATING TO~~  
6 ~~DEFINITIONS).~~

7 "HEALTH CARE SERVICE." ANY COVERED TREATMENT, ADMISSION,  
8 PROCEDURE, MEDICAL SUPPLIES AND EQUIPMENT OR OTHER SERVICES,  
9 INCLUDING BEHAVIORAL HEALTH, PRESCRIBED OR OTHERWISE PROVIDED OR  
10 PROPOSED TO BE PROVIDED BY A HEALTH CARE PROVIDER TO [AN] A  
11 COVERED PERSON OR ENROLLEE [UNDER A MANAGED CARE PLAN CONTRACT.]  
12 FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE OR RELIEF OF A  
13 HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE OR FUNCTIONAL <--  
14 LIMITATION UNDER THE TERMS OF EITHER A HEALTH INSURANCE POLICY  
15 OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES. THE TERM <--  
16 INCLUDES HOME AND COMMUNITY BASED SERVICES PROVIDED TO AN  
17 ENROLLEE UNDER THE TERMS OF AN AGREEMENT WITH THE DEPARTMENT OF  
18 HUMAN SERVICES.

19 "HEALTH INSURANCE POLICY." A POLICY, SUBSCRIBER CONTRACT,  
20 CERTIFICATE OR PLAN ISSUED BY AN INSURER THAT PROVIDES MEDICAL  
21 OR HEALTH CARE COVERAGE. THE TERM DOES NOT INCLUDE ANY OF THE  
22 FOLLOWING:

- 23 (1) AN ACCIDENT ONLY POLICY.
- 24 (2) A CREDIT ONLY POLICY.
- 25 (3) A LONG-TERM CARE OR DISABILITY INCOME POLICY.
- 26 (4) A SPECIFIED DISEASE POLICY.
- 27 (5) A MEDICARE SUPPLEMENT POLICY.
- 28 (6) A TRICARE POLICY, INCLUDING A CIVILIAN HEALTH AND  
29 MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT  
30 POLICY.

1       (7) A FIXED INDEMNITY POLICY.  
2       (8) A HOSPITAL INDEMNITY POLICY.  
3       (9) A DENTAL ONLY POLICY.  
4       (10) A VISION ONLY POLICY.  
5       (11) A WORKERS' COMPENSATION POLICY.  
6       (12) AN AUTOMOBILE MEDICAL PAYMENT POLICY UNDER 75 PA.C.S.  
7 (RELATING TO VEHICLES).  
8       (13) A HOMEOWNER'S INSURANCE POLICY.  
9       (14) ANY OTHER SIMILAR POLICIES PROVIDING FOR LIMITED  
10 BENEFITS.  
11       "INDEPENDENT REVIEW ORGANIZATION" OR "IRO." AN ENTITY  
12 APPROVED BY THE DEPARTMENT UNDER SECTION ~~2161.10~~ 2164.9 THAT <--  
13 CONDUCTS INDEPENDENT REVIEWS OF ADVERSE BENEFIT DETERMINATIONS,  
14 FINAL ADVERSE BENEFIT DETERMINATIONS AND GRIEVANCES.  
15       ~~"INPATIENT ADMISSION." ADMISSION TO A FACILITY FOR PURPOSES~~ <--  
16 ~~OF RECEIVING A HEALTH CARE SERVICE.~~  
17       "INSURER." AN ENTITY LICENSED BY THE DEPARTMENT THAT OFFERS,  
18 ISSUES OR RENEWS AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY  
19 THAT IS OFFERED OR GOVERNED UNDER ANY OF THE FOLLOWING:  
20       (1) THIS ACT, INCLUDING SECTION 630 AND ARTICLE XXIV.  
21       (2) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN  
22 AS THE "HEALTH MAINTENANCE ORGANIZATION ACT."  
23       (3) 40 PA.C.S. CH. 61 (RELATING TO HEALTH PLAN CORPORATIONS)  
24 OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN  
25 CORPORATIONS).  
26       THE TERM DOES NOT INCLUDE AN ENTITY OPERATING AS AN MA OR  
27 CHIP MANAGED CARE PLAN.  
28       ["MANAGED CARE PLAN." A HEALTH CARE PLAN THAT USES A  
29 GATEKEEPER TO MANAGE THE UTILIZATION OF HEALTH CARE SERVICES,  
30 INTEGRATES THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES TO

1 ENROLLEES BY ARRANGEMENTS WITH HEALTH CARE PROVIDERS SELECTED TO  
2 PARTICIPATE ON THE BASIS OF SPECIFIC STANDARDS AND PROVIDES  
3 FINANCIAL INCENTIVES FOR ENROLLEES TO USE THE PARTICIPATING  
4 HEALTH CARE PROVIDERS IN ACCORDANCE WITH PROCEDURES ESTABLISHED  
5 BY THE PLAN. A MANAGED CARE PLAN INCLUDES HEALTH CARE ARRANGED  
6 THROUGH AN ENTITY OPERATING UNDER ANY OF THE FOLLOWING:

7 (1) SECTION 630.

8 (2) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN  
9 AS THE "HEALTH MAINTENANCE ORGANIZATION ACT."

10 (3) THE ACT OF DECEMBER 14, 1992 (P.L.835, NO.134), KNOWN AS  
11 THE "FRATERNAL BENEFIT SOCIETIES CODE."

12 (4) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN  
13 CORPORATIONS).

14 (5) 40 PA.C.S. CH. 63 (RELATING TO PROFESSIONAL HEALTH  
15 SERVICES PLAN CORPORATIONS).

16 THE TERM INCLUDES AN ENTITY, INCLUDING A MUNICIPALITY,  
17 WHETHER LICENSED OR UNLICENSED, THAT CONTRACTS WITH OR FUNCTIONS  
18 AS A MANAGED CARE PLAN TO PROVIDE HEALTH CARE SERVICES TO  
19 ENROLLEES. THE TERM DOES NOT INCLUDE ANCILLARY SERVICE PLANS OR  
20 AN INDEMNITY ARRANGEMENT WHICH IS PRIMARILY FEE FOR SERVICE.]

21 "MEDICAL ASSISTANCE OR CHILDREN'S HEALTH INSURANCE PROGRAM  
22 MANAGED CARE PLAN" OR "MA OR CHIP MANAGED CARE PLAN." A HEALTH  
23 CARE PLAN THAT USES A GATEKEEPER TO MANAGE THE UTILIZATION OF  
24 HEALTH CARE SERVICES BY MEDICAL ASSISTANCE OR CHILDREN'S HEALTH  
25 INSURANCE PROGRAM ENROLLEES AND INTEGRATES THE FINANCING AND  
26 DELIVERY OF HEALTH CARE SERVICES TO ENROLLEES BY ARRANGEMENTS <--  
27 WITH HEALTH CARE PROVIDERS SELECTED TO PARTICIPATE.

28 "MEDICAL OR SCIENTIFIC EVIDENCE." EVIDENCE FOUND IN ANY OF  
29 THE FOLLOWING SOURCES:

30 (1) A PEER-REVIEWED SCIENTIFIC STUDY PUBLISHED IN OR

1 ACCEPTED FOR PUBLICATION BY A MEDICAL JOURNAL THAT MEETS  
2 NATIONALLY RECOGNIZED REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS  
3 AND WHICH JOURNAL SUBMITS MOST OF ITS PUBLISHED ARTICLES FOR  
4 REVIEW BY EXPERTS WHO ARE NOT PART OF THE JOURNAL'S EDITORIAL  
5 STAFF.

6 (2) PEER-REVIEWED MEDICAL LITERATURE, INCLUDING LITERATURE  
7 RELATING TO A THERAPY REVIEWED AND APPROVED BY A QUALIFIED  
8 INSTITUTIONAL REVIEW BOARD, BIOMEDICAL COMPENDIA AND OTHER  
9 MEDICAL LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL  
10 INSTITUTES OF HEALTH'S LIBRARY OF MEDICINE FOR INDEXING IN INDEX  
11 MEDICUS (MEDLINE) AND ELSEVIER SCIENCE LIMITED FOR INDEXING IN  
12 EXCERPTA MEDICA (EMBASE).

13 (3) A MEDICAL JOURNAL RECOGNIZED BY THE SECRETARY OF HEALTH  
14 AND HUMAN SERVICES UNDER SECTION 1861(T)(2) OF THE SOCIAL  
15 SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395X(T)(2)).

16 (4) ONE OF THE FOLLOWING STANDARD REFERENCE COMPENDIA:

17 (I) THE AMERICAN HOSPITAL FORMULARY SERVICE-DRUG  
18 INFORMATION.

19 (II) DRUGDEX INFORMATION SYSTEM.

20 (III) THE AMERICAN DENTAL ASSOCIATION ACCEPTED DENTAL  
21 THERAPEUTICS.

22 (IV) THE UNITED STATES PHARMACOPOEIA-DRUG INFORMATION.

23 (5) FINDINGS, STUDIES OR RESEARCH CONDUCTED BY OR UNDER THE  
24 AUSPICES OF A UNITED STATES GOVERNMENT AGENCY OR NATIONALLY  
25 RECOGNIZED FEDERAL RESEARCH INSTITUTE, INCLUDING:

26 (I) THE UNITED STATES AGENCY FOR HEALTHCARE RESEARCH AND  
27 QUALITY.

28 (II) THE NATIONAL INSTITUTES OF HEALTH.

29 (III) THE NATIONAL CANCER INSTITUTE.

30 (IV) THE NATIONAL ACADEMY OF SCIENCES.

1 (V) THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN  
2 SERVICES.

3 (VI) THE FOOD AND DRUG ADMINISTRATION.

4 (VII) ANY NATIONAL BOARD RECOGNIZED BY THE NATIONAL  
5 INSTITUTES OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL  
6 VALUE OF HEALTH CARE SERVICES.

7 (6) OTHER MEDICAL OR SCIENTIFIC EVIDENCE THAT IS COMPARABLE  
8 TO THE SOURCES SPECIFIED IN PARAGRAPHS (1), (2), (3), (4) AND  
9 (5).

10 "MEDICAL POLICY." A WRITTEN DOCUMENT ADOPTED, MAINTAINED AND  
11 APPLIED BY AN INSURER OR MA OR CHIP MANAGED CARE PLAN THAT  
12 COMBINES THE CLINICAL REVIEW CRITERIA AND ANY ADDITIONAL  
13 ADMINISTRATIVE REQUIREMENTS POLICY, AS APPLICABLE, NECESSARY TO <--  
14 ARTICULATE THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
15 STANDARDS FOR COVERAGE OF A GIVEN HEALTH CARE SERVICE OR SET OF  
16 HEALTH CARE SERVICES UNDER THE TERMS OF A HEALTH INSURANCE  
17 POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

18 "MEDICATION-ASSISTED TREATMENT." UNITED STATES FOOD AND DRUG <--  
19 ADMINISTRATION APPROVED PRESCRIPTION DRUGS USED IN COMBINATION  
20 WITH COUNSELING AND BEHAVIORAL HEALTH THERAPIES AND MANAGEMENT  
21 IN THE TREATMENT OF OPIOID USE DISORDERS. THE USE OF UNITED <--  
22 STATES FOOD AND DRUG ADMINISTRATION-APPROVED MEDICATIONS ALONG  
23 WITH TREATMENT OTHER THAN MEDICATION, AS CLINICALLY INDICATED,  
24 TO TREAT SUBSTANCE USE DISORDERS, INCLUDING OPIOID USE  
25 DISORDERS.

26 "NAIC." THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

27 "NATIONALLY RECOGNIZED MEDICAL STANDARDS." CLINICAL  
28 CRITERIA, PRACTICE GUIDELINES AND RELATED STANDARDS ESTABLISHED  
29 BY NATIONAL QUALITY AND ACCREDITATION ENTITIES GENERALLY  
30 RECOGNIZED IN THE UNITED STATES HEALTH CARE INDUSTRY.

1 "PARTICIPATING HEALTH CARE PROVIDER." A HEALTH CARE PROVIDER  
2 THAT HAS ENTERED INTO A CONTRACTUAL OR OPERATING RELATIONSHIP  
3 WITH AN INSURER OR MA OR CHIP MANAGED CARE PLAN TO PARTICIPATE  
4 IN ONE OR MORE DESIGNATED NETWORKS OF THE INSURER OR MA OR CHIP <--  
5 MANAGED CARE PLAN AND TO PROVIDE HEALTH CARE SERVICES TO COVERED  
6 PERSONS OR ENROLLEES UNDER THE TERMS OF THE INSURER'S  
7 ADMINISTRATIVE POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF  
8 HUMAN SERVICES.

9 ["PLAN." A MANAGED CARE PLAN.]

10 "PRESCRIPTION DRUG." A DRUG OR BIOLOGICAL PRODUCT, AS BOTH  
11 OF THOSE TERMS ARE DEFINED IN THE ACT OF NOVEMBER 24, 1976  
12 (P.L.1163, NO.259), REFERRED TO AS THE GENERIC EQUIVALENT DRUG  
13 LAW.

14 "PRIMARY CARE PROVIDER." A HEALTH CARE PROVIDER WHO, WITHIN  
15 THE SCOPE OF THE PROVIDER'S PRACTICE, SUPERVISES, COORDINATES,  
16 PRESCRIBES OR OTHERWISE PROVIDES OR PROPOSES TO PROVIDE HEALTH  
17 CARE SERVICES TO [AN] A COVERED PERSON OR ENROLLEE, INITIATES  
18 [ENROLLEE] A REFERRAL FOR SPECIALIST CARE AND MAINTAINS  
19 CONTINUITY OF [ENROLLEE] CARE FOR THE COVERED PERSON OR  
20 ENROLLEE.

21 ~~"PRIMARY CONTRACTOR." A COUNTY, CONSORTIUM OF COUNTIES, MA~~ <--  
22 ~~OR CHIP MANAGED CARE PLAN OR OTHER ENTITY THAT HAS AN AGREEMENT~~  
23 ~~WITH THE DEPARTMENT OF HUMAN SERVICES TO MANAGE THE PURCHASE AND~~  
24 ~~PROVISION OF BEHAVIOR HEALTH SERVICES.~~

25 "PRIOR AUTHORIZATION." A PROSPECTIVE UTILIZATION REVIEW  
26 PERFORMED BY AN INSURER OR MA OR CHIP MANAGED CARE PLAN, OR BY A  
27 UTILIZATION REVIEW ENTITY ACTING ON BEHALF OF AN INSURER OR MA  
28 OR CHIP MANAGED CARE PLAN, OF ALL REASONABLY NECESSARY  
29 SUPPORTING INFORMATION THAT OCCURS PRIOR TO THE DELIVERY OR  
30 PROVISION OF A HEALTH CARE SERVICE AND RESULTS IN A DECISION TO

1 APPROVE OR DENY PAYMENT FOR THE HEALTH CARE SERVICE. THE TERM  
2 INCLUDES STEP THERAPY AND STEP THERAPY EXCEPTION REQUESTS.

3 "PRIOR AUTHORIZATION REQUEST." A REQUEST FOR PRIOR  
4 AUTHORIZATION OF A HEALTH CARE SERVICE THAT MEETS AN INSURER'S  
5 OR MA OR CHIP MANAGED CARE PLAN'S ADMINISTRATIVE POLICY  
6 REQUIREMENTS FOR SUCH A REQUEST AND INCLUDES THE SPECIFIC <--  
7 CLINICAL INFORMATION NECESSARY TO EVALUATE THE REQUEST UNDER THE  
8 TERMS OF THE APPLICABLE MEDICAL POLICY.

9 ["PROSPECTIVE UTILIZATION REVIEW." A REVIEW BY A UTILIZATION  
10 REVIEW ENTITY OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION  
11 THAT OCCURS PRIOR TO THE DELIVERY OR PROVISION OF A HEALTH CARE  
12 SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR  
13 THE HEALTH CARE SERVICE.]

14 "PROTECTED HEALTH INFORMATION." INFORMATION OR DATA, WHETHER  
15 ORAL OR RECORDED IN ANY FORM OR MEDIUM, AND PERSONAL FACTS OR  
16 INFORMATION ABOUT EVENTS OR RELATIONSHIPS THAT IDENTIFIES AN  
17 INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION OR FOR WHICH  
18 THERE IS A REASONABLE BASIS TO BELIEVE THAT THE INFORMATION  
19 COULD BE USED TO IDENTIFY AN INDIVIDUAL, THAT RELATES TO ANY OF  
20 THE FOLLOWING:

21 (1) THE PAST, PRESENT, OR FUTURE PHYSICAL, MENTAL OR  
22 BEHAVIORAL HEALTH OR CONDITION OF AN INDIVIDUAL OR A MEMBER OF  
23 THE INDIVIDUAL'S FAMILY.

24 (2) THE PROVISION OF HEALTH CARE SERVICES TO AN INDIVIDUAL.

25 (3) PAYMENT FOR THE PROVISION OF HEALTH CARE SERVICES TO AN  
26 INDIVIDUAL.

27 "PROVIDER NETWORK." [THE] PARTICIPATING HEALTH CARE <--  
28 PROVIDERS DESIGNATED BY [A] AN INSURER OR MA OR CHIP MANAGED  
29 CARE PLAN TO PROVIDE HEALTH CARE SERVICES UNDER A HEALTH  
30 INSURANCE POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN

1 SERVICES.

2 "PROVIDER PORTAL." A DESIGNATED SECTION OR FUNCTIONAL  
3 SOFTWARE MODULE ACCESSIBLE VIA AN INSURER'S OR MA OR CHIP  
4 MANAGED CARE PLAN'S PUBLICLY ACCESSIBLE INTERNET WEBSITE THAT  
5 FACILITATES HEALTH CARE PROVIDER SUBMISSION OF ELECTRONIC PRIOR  
6 AUTHORIZATION REQUESTS.

7 "REFERRAL." A PRIOR AUTHORIZATION FROM [A] AN INSURER, MA OR  
8 CHIP MANAGED CARE PLAN OR A PARTICIPATING HEALTH CARE PROVIDER  
9 THAT ALLOWS [AN] A COVERED PERSON OR ENROLLEE TO HAVE ONE OR  
10 MORE APPOINTMENTS WITH A HEALTH CARE PROVIDER FOR A HEALTH CARE  
11 SERVICE.

12 "RETROSPECTIVE UTILIZATION REVIEW." [A REVIEW BY A  
13 UTILIZATION REVIEW ENTITY OF ALL REASONABLY NECESSARY SUPPORTING  
14 INFORMATION WHICH OCCURS FOLLOWING DELIVERY OR PROVISION OF A  
15 HEALTH CARE SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY  
16 PAYMENT FOR THE HEALTH CARE SERVICE.] REVIEW OF MEDICAL  
17 NECESSITY PERFORMED BY AN INSURER OR MA OR CHIP MANAGED CARE  
18 PLAN, OR BY A UTILIZATION REVIEW ENTITY ACTING ON BEHALF OF AN  
19 INSURER OR MA OR CHIP MANAGED CARE PLAN AND CONDUCTED AFTER  
20 HEALTH CARE SERVICES HAVE BEEN PROVIDED TO A COVERED PERSON OR  
21 ENROLLEE, NOT INCLUDING THE REVIEW OF A CLAIM THAT IS LIMITED TO <--  
22 AN EVALUATION OF THE REIMBURSEMENT LEVELS, VERACITY OF  
23 DOCUMENTATION, ACCURACY OF CODING OR ADJUSTMENT FOR PAYMENT.

24 "SERVICE AREA." THE GEOGRAPHIC AREA FOR WHICH [THE] AN  
25 INSURER OR MA OR CHIP MANAGED CARE PLAN IS LICENSED OR HAS BEEN  
26 ISSUED A CERTIFICATE OF AUTHORITY.

27 "SPECIALIST." A HEALTH CARE PROVIDER WHOSE PRACTICE IS NOT  
28 LIMITED TO PRIMARY HEALTH CARE SERVICES AND WHO HAS ADDITIONAL  
29 POSTGRADUATE OR SPECIALIZED TRAINING, HAS BOARD CERTIFICATION OR  
30 PRACTICES IN A LICENSED SPECIALIZED AREA OF HEALTH CARE. THE



1 TERM INCLUDES A HEALTH CARE PROVIDER WHO IS NOT CLASSIFIED BY  
2 [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SOLELY AS A  
3 PRIMARY CARE PROVIDER.

4 "STEP THERAPY." A COURSE OF TREATMENT IN WHICH CERTAIN  
5 DESIGNATED DRUGS OR TREATMENT PROTOCOLS MUST BE EITHER  
6 CONTRAINDICATED, OR USED AND FOUND TO BE INEFFECTIVE, PRIOR TO  
7 APPROVAL OF COVERAGE OF OTHER DESIGNATED DRUGS OR TREATMENT  
8 PROTOCOLS. THE TERM DOES NOT INCLUDE REQUESTS FOR COVERAGE OF  
9 NONFORMULARY DRUGS.

10 "URGENT HEALTH CARE SERVICE." A COVERED HEALTH CARE SERVICE  
11 SUBJECT TO PRIOR AUTHORIZATION THAT IS DELIVERED ON AN EXPEDITED  
12 BASIS FOR THE TREATMENT OF AN ACUTE CONDITION WITH SYMPTOMS OF  
13 SUFFICIENT SEVERITY PURSUANT TO A DETERMINATION BY A LICENSED  
14 TREATING PHYSICIAN, OPERATING WITH THE INDIVIDUAL'S SCOPE OF  
15 PRACTICE AND PROFESSIONAL EXPERTISE, THAT THE FAILURE TO PROVIDE  
16 THE SERVICE IS LIKELY TO RESULT IN SERIOUS, LONG-TERM HEALTH  
17 COMPLICATIONS OR A MATERIAL DETERIORATION IN THE COVERED  
18 PERSON'S OR ENROLLEE'S CONDITION AND PROGNOSIS.

19 ~~"URGENT REQUEST." A REQUEST FOR PRIOR AUTHORIZATION OF AN~~ <--  
20 ~~URGENT HEALTHCARE SERVICE.~~

21 "UTILIZATION REVIEW." [A SYSTEM OF PROSPECTIVE, CONCURRENT  
22 OR RETROSPECTIVE UTILIZATION REVIEW PERFORMED BY A UTILIZATION  
23 REVIEW ENTITY OF THE MEDICAL NECESSITY AND APPROPRIATENESS OF  
24 HEALTH CARE SERVICES PRESCRIBED, PROVIDED OR PROPOSED TO BE  
25 PROVIDED TO AN ENROLLEE. THE TERM DOES NOT INCLUDE ANY OF THE  
26 FOLLOWING:

27 (1) REQUESTS FOR CLARIFICATION OF COVERAGE, ELIGIBILITY OR  
28 HEALTH CARE SERVICE VERIFICATION.

29 (2) A HEALTH CARE PROVIDER'S INTERNAL QUALITY ASSURANCE OR  
30 UTILIZATION REVIEW PROCESS UNLESS THE REVIEW RESULTS IN DENIAL

1 OF PAYMENT FOR A HEALTH CARE SERVICE.] A SET OF FORMAL  
2 TECHNIQUES DESIGNED TO MONITOR THE USE OF OR EVALUATE THE  
3 MEDICAL NECESSITY, APPROPRIATENESS, EFFICACY OR EFFICIENCY OF  
4 HEALTH CARE SERVICES, PROCEDURES OR SETTINGS, INCLUDING PRIOR  
5 AUTHORIZATION, SECOND OPINION, CERTIFICATION, CONCURRENT REVIEW,  
6 CASE MANAGEMENT, DISCHARGE PLANNING OR RETROSPECTIVE REVIEW, IN  
7 ORDER TO MAKE A DETERMINATION REGARDING COVERAGE OF THE SERVICE  
8 UNDER THE TERMS OF A HEALTH INSURANCE POLICY OR AN AGREEMENT  
9 WITH THE DEPARTMENT OF HUMAN SERVICES.

10 "UTILIZATION REVIEW ENTITY." ANY ENTITY CERTIFIED PURSUANT  
11 TO SUBDIVISION (H) THAT PERFORMS UTILIZATION REVIEW ON BEHALF OF  
12 [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN.

13 (B) INSURER AND MA AND CHIP MANAGED CARE  
14 PLAN REQUIREMENTS.

15 SECTION 2111. RESPONSIBILITIES OF INSURERS AND MA AND CHIP  
16 MANAGED CARE PLANS.--[A] AN INSURER OR MA OR CHIP MANAGED CARE  
17 PLAN SHALL DO ALL OF THE FOLLOWING:

18 (1) ASSURE AVAILABILITY AND ACCESSIBILITY OF ADEQUATE HEALTH  
19 CARE PROVIDERS IN A TIMELY MANNER, WHICH ENABLES COVERED PERSONS  
20 OR ENROLLEES TO HAVE ACCESS TO QUALITY CARE AND CONTINUITY OF  
21 HEALTH CARE SERVICES.

22 (2) CONSULT WITH HEALTH CARE PROVIDERS IN ACTIVE CLINICAL  
23 PRACTICE REGARDING PROFESSIONAL QUALIFICATIONS AND NECESSARY  
24 SPECIALISTS TO BE INCLUDED IN [THE PLAN.] ~~COVERAGE~~ THE PROVIDER <--  
25 NETWORK UNDER A HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE  
26 DEPARTMENT OF HUMAN SERVICES.

27 (3) ADOPT AND MAINTAIN A DEFINITION OF MEDICAL NECESSITY  
28 USED BY ~~THE~~ AN INSURER OR MA OR CHIP MANAGED CARE PLAN IN <--  
29 DETERMINING AUTHORIZATION OF HEALTH CARE SERVICES. <--

30 (4) ENSURE THAT EMERGENCY SERVICES ARE PROVIDED TWENTY-FOUR

1 (24) HOURS A DAY, SEVEN (7) DAYS A WEEK AND PROVIDE REASONABLE  
2 PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES.

3 (5) ADOPT AND MAINTAIN PROCEDURES BY WHICH [AN] A COVERED  
4 PERSON OR ENROLLEE CAN OBTAIN HEALTH CARE SERVICES OUTSIDE THE  
5 HEALTH INSURANCE POLICY'S OR MA OR CHIP MANAGED CARE PLAN'S  
6 SERVICE AREA.

7 (6) ADOPT AND MAINTAIN PROCEDURES BY WHICH [AN] A COVERED  
8 PERSON OR ENROLLEE WITH A LIFE-THREATENING, DEGENERATIVE OR  
9 DISABLING DISEASE OR CONDITION SHALL, UPON REQUEST, RECEIVE AN  
10 EVALUATION AND, IF THE HEALTH INSURANCE POLICY'S [PLAN'S]  
11 ESTABLISHED STANDARDS ARE MET OR THE STANDARDS ESTABLISHED BY AN  
12 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES, BE PERMITTED TO  
13 RECEIVE:

14 (I) A STANDING REFERRAL TO A SPECIALIST WITH CLINICAL  
15 EXPERTISE IN TREATING THE DISEASE OR CONDITION; OR

16 (II) THE DESIGNATION OF A SPECIALIST TO PROVIDE AND  
17 COORDINATE THE COVERED PERSON'S OR ENROLLEE'S PRIMARY AND  
18 SPECIALTY CARE.

19 THE REFERRAL TO OR DESIGNATION OF A SPECIALIST SHALL BE PURSUANT  
20 TO A TREATMENT PLAN APPROVED BY THE INSURER OR MA OR CHIP  
21 MANAGED CARE PLAN IN CONSULTATION WITH THE PRIMARY CARE  
22 PROVIDER, THE COVERED PERSON OR ENROLLEE AND, AS APPROPRIATE,  
23 THE SPECIALIST. WHEN POSSIBLE, THE SPECIALIST MUST BE A HEALTH  
24 CARE PROVIDER PARTICIPATING IN THE [PLAN.] HEALTH INSURANCE  
25 POLICY OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER NETWORK.

26 (7) PROVIDE DIRECT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL  
27 SERVICES BY PERMITTING [AN] A COVERED PERSON OR ENROLLEE TO  
28 SELECT A HEALTH CARE PROVIDER PARTICIPATING IN THE [PLAN] HEALTH  
29 INSURANCE POLICY OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER  
30 NETWORK TO OBTAIN MATERNITY AND GYNECOLOGICAL CARE, INCLUDING

1 MEDICALLY NECESSARY AND APPROPRIATE FOLLOW-UP CARE AND REFERRALS  
2 FOR DIAGNOSTIC TESTING RELATED TO MATERNITY AND GYNECOLOGICAL  
3 CARE, WITHOUT PRIOR APPROVAL FROM A PRIMARY CARE PROVIDER. THE  
4 HEALTH CARE SERVICES SHALL BE WITHIN THE SCOPE OF PRACTICE OF  
5 THE SELECTED HEALTH CARE PROVIDER. THE SELECTED HEALTH CARE  
6 PROVIDER SHALL INFORM THE COVERED PERSON'S OR ENROLLEE'S PRIMARY  
7 CARE PROVIDER OF ALL HEALTH CARE SERVICES PROVIDED.

8 (8) ADOPT AND MAINTAIN A COMPLAINT PROCESS AS SET FORTH IN  
9 SUBDIVISION (G).

10 (9) ADOPT AND MAINTAIN A GRIEVANCE PROCESS AS SET FORTH IN  
11 SUBDIVISION (I).

12 (10) ADOPT AND MAINTAIN CREDENTIALING STANDARDS FOR HEALTH  
13 CARE PROVIDERS AS SET FORTH IN SUBDIVISION (D).

14 (11) ENSURE THAT THERE ARE PARTICIPATING HEALTH CARE  
15 PROVIDERS THAT ARE PHYSICALLY ACCESSIBLE TO PEOPLE WITH  
16 DISABILITIES AND CAN COMMUNICATE WITH INDIVIDUALS WITH SENSORY  
17 DISABILITIES IN ACCORDANCE WITH TITLE III OF THE AMERICANS WITH  
18 DISABILITIES ACT OF 1990 (PUBLIC LAW 101-336, 42 U.S.C. § 12181  
19 ET SEQ.).

20 (12) PROVIDE A LIST OF HEALTH CARE PROVIDERS PARTICIPATING  
21 IN THE [PLAN] HEALTH INSURANCE POLICY OR MA OR CHIP MANAGED CARE  
22 PLAN'S PROVIDER NETWORK TO THE DEPARTMENT EVERY TWO (2) YEARS OR  
23 AS MAY OTHERWISE BE REQUIRED BY THE DEPARTMENT. THE LIST SHALL  
24 INCLUDE THE EXTENT TO WHICH HEALTH CARE PROVIDERS IN THE [PLAN]  
25 HEALTH INSURANCE POLICY OR MA OR CHIP MANAGED CARE PLAN'S  
26 PROVIDER NETWORK ARE ACCEPTING NEW ENROLLEES.

27 (13) REPORT TO THE DEPARTMENT [AND THE INSURANCE DEPARTMENT]  
28 IN ACCORDANCE WITH THE REQUIREMENTS OF THIS ARTICLE. SUCH  
29 INFORMATION SHALL INCLUDE THE NUMBER, TYPE AND DISPOSITION OF  
30 ALL COMPLAINTS [AND], GRIEVANCES [FILED WITH THE PLAN.] AND

1 ADVERSE BENEFIT DETERMINATIONS FILED WITH THE INSURER UNDER A  
2 HEALTH INSURANCE POLICY OR WITH THE MA OR CHIP MANAGED CARE  
3 PLAN, AS APPLICABLE.

4 SECTION 2112. FINANCIAL INCENTIVES PROHIBITION.--NO INSURER  
5 OR MA OR CHIP MANAGED CARE PLAN ~~†SHALL†~~ ~~MAY~~ USE ANY FINANCIAL <--  
6 INCENTIVE THAT COMPENSATES A HEALTH CARE PROVIDER FOR PROVIDING  
7 LESS THAN MEDICALLY NECESSARY AND APPROPRIATE CARE TO [AN] A  
8 COVERED PERSON OR ENROLLEE. NOTHING IN THIS SECTION SHALL BE  
9 DEEMED TO PROHIBIT [A] AN INSURER OR MA OR CHIP MANAGED CARE  
10 PLAN FROM USING A CAPITATED PAYMENT ARRANGEMENT OR OTHER RISK-  
11 SHARING ARRANGEMENT.

12 SECTION 2113. MEDICAL GAG CLAUSE PROHIBITION.-- (A) NO  
13 INSURER OR MA OR CHIP MANAGED CARE PLAN MAY PENALIZE OR RESTRICT  
14 A HEALTH CARE PROVIDER FROM DISCUSSING ANY OF THE FOLLOWING:

15 (1) [THE] THE PROCESS THAT THE INSURER OR MA OR CHIP MANAGED  
16 CARE PLAN OR ANY ENTITY CONTRACTING WITH THE INSURER OR MA OR  
17 CHIP MANAGED CARE PLAN USES OR PROPOSES TO USE TO DENY PAYMENT  
18 FOR A HEALTH CARE SERVICE[;].

19 (2) [MEDICALLY] MEDICALLY NECESSARY AND APPROPRIATE CARE  
20 WITH OR ON BEHALF OF [AN] A COVERED PERSON OR ENROLLEE,  
21 INCLUDING INFORMATION REGARDING THE NATURE OF TREATMENT; RISKS  
22 OF TREATMENT; ALTERNATIVE TREATMENTS; OR THE AVAILABILITY OF  
23 ALTERNATE THERAPIES, CONSULTATION OR TESTS[; OR].

24 (3) [THE] THE DECISION OF [ANY] AN INSURER OR MA OR CHIP  
25 MANAGED CARE PLAN TO DENY PAYMENT FOR A HEALTH CARE SERVICE.

26 (B) A PROVISION TO PROHIBIT OR RESTRICT DISCLOSURE OF  
27 MEDICALLY NECESSARY AND APPROPRIATE HEALTH CARE INFORMATION  
28 CONTAINED IN A CONTRACT WITH A HEALTH CARE PROVIDER IS CONTRARY  
29 TO PUBLIC POLICY AND SHALL BE VOID AND UNENFORCEABLE.

30 (C) NO INSURER OR MA OR CHIP MANAGED CARE PLAN ~~†SHALL†~~ ~~MAY~~ <--

1 TERMINATE THE EMPLOYMENT OF OR A CONTRACT WITH A HEALTH CARE  
2 PROVIDER FOR ANY OF THE FOLLOWING:

3 (1) ADVOCATING FOR MEDICALLY NECESSARY AND APPROPRIATE  
4 HEALTH CARE CONSISTENT WITH THE DEGREE OF LEARNING AND SKILL  
5 ORDINARILY POSSESSED BY A REPUTABLE HEALTH CARE PROVIDER  
6 PRACTICING ACCORDING TO THE APPLICABLE LEGAL STANDARD OF CARE.

7 (2) FILING A COMPLAINT, GRIEVANCE OR EXTERNAL REVIEW  
8 PURSUANT TO THE PROCEDURES SET FORTH IN THIS ARTICLE.

9 (3) PROTESTING A DECISION, POLICY OR PRACTICE THAT THE  
10 HEALTH CARE PROVIDER, CONSISTENT WITH THE DEGREE OF LEARNING AND  
11 SKILL ORDINARILY POSSESSED BY A REPUTABLE HEALTH CARE PROVIDER  
12 PRACTICING ACCORDING TO THE APPLICABLE LEGAL STANDARD OF CARE,  
13 REASONABLY BELIEVES INTERFERES WITH THE HEALTH CARE PROVIDER'S  
14 ABILITY TO PROVIDE MEDICALLY NECESSARY AND APPROPRIATE HEALTH  
15 CARE.

16 (D) NOTHING IN THIS SECTION SHALL:

17 (1) PROHIBIT [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN  
18 FROM MAKING A DETERMINATION NOT TO PAY FOR A PARTICULAR MEDICAL  
19 TREATMENT, SUPPLY OR SERVICE, ENFORCING REASONABLE PEER REVIEW  
20 OR UTILIZATION REVIEW PROTOCOLS OR MAKING A DETERMINATION THAT A  
21 HEALTH CARE PROVIDER HAS OR HAS NOT COMPLIED WITH APPROPRIATE  
22 PROTOCOLS.

23 (2) BE CONSTRUED AS REQUIRING [A] AN INSURER OR MA OR CHIP  
24 MANAGED CARE PLAN TO PROVIDE, REIMBURSE FOR OR COVER COUNSELING,  
25 REFERRAL OR OTHER HEALTH CARE SERVICES IF THE INSURER OR MA OR  
26 CHIP MANAGED CARE PLAN:

27 (I) OBJECTS TO THE PROVISION OF THAT SERVICE ON MORAL OR  
28 RELIGIOUS GROUNDS; AND

29 (II) MAKES AVAILABLE INFORMATION ON ITS POLICIES REGARDING  
30 SUCH HEALTH CARE SERVICES TO COVERED PERSON OR ENROLLEES AND

1 PROSPECTIVE COVERED PERSON OR ENROLLEES.

2 SECTION 2116. EMERGENCY SERVICES.-- (A) IF [AN] A COVERED  
3 PERSON OR ENROLLEE SEEKS EMERGENCY SERVICES AND THE EMERGENCY  
4 HEALTH CARE PROVIDER DETERMINES THAT EMERGENCY SERVICES ARE  
5 NECESSARY, THE EMERGENCY HEALTH CARE PROVIDER SHALL INITIATE  
6 NECESSARY INTERVENTION TO EVALUATE AND, IF NECESSARY, STABILIZE  
7 THE CONDITION OF THE COVERED PERSON OR ENROLLEE WITHOUT SEEKING  
8 OR RECEIVING AUTHORIZATION FROM THE INSURER OR MA OR CHIP  
9 MANAGED CARE PLAN. THE INSURER OR MA OR CHIP MANAGED CARE PLAN  
10 MAY NOT REQUIRE A HEALTH CARE PROVIDER TO SUBMIT A REQUEST FOR  
11 PRIOR AUTHORIZATION FOR AN EMERGENCY SERVICE. THE INSURER OR MA  
12 OR CHIP MANAGED CARE PLAN SHALL PAY ALL REASONABLY NECESSARY  
13 COSTS ASSOCIATED WITH EMERGENCY SERVICES PROVIDED DURING THE  
14 PERIOD OF EMERGENCY, SUBJECT TO ALL COPAYMENTS, COINSURANCES OR  
15 DEDUCTIBLES. WHEN PROCESSING A REIMBURSEMENT CLAIM FOR EMERGENCY  
16 SERVICES, [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
17 CONSIDER BOTH THE PRESENTING SYMPTOMS AND THE SERVICES PROVIDED.

18 (A.1) THE EMERGENCY HEALTH CARE PROVIDER SHALL NOTIFY THE  
19 COVERED PERSON'S INSURER OR ENROLLEE'S MA OR CHIP MANAGED CARE  
20 PLAN OF THE PROVISION OF EMERGENCY SERVICES AND THE CONDITION OF  
21 THE COVERED PERSON OR ENROLLEE.

22 (1) THE HEALTH CARE PROVIDER SHALL NOTIFY A COVERED PERSON'S  
23 INSURER OF THE PROVISION OF EMERGENCY SERVICES AND THE CONDITION  
24 OF THE COVERED PERSON WITHIN TWO BUSINESS DAYS FOLLOWING THE  
25 PERIOD OF EMERGENCY.

26 (2) THE HEALTH CARE PROVIDER SHALL NOTIFY THE ENROLLEE'S MA  
27 OR CHIP MANAGED CARE PLAN OF THE PROVISION OF EMERGENCY SERVICES  
28 AND THE CONDITION OF THE ENROLLEE WITHIN TEN DAYS FOLLOWING THE  
29 PERIOD OF EMERGENCY PRESENTATION FOR EMERGENCY SERVICES. <--

30 (A.2) IF [AN] A COVERED PERSON'S OR ENROLLEE'S CONDITION HAS

1 STABILIZED AND THE COVERED PERSON OR ENROLLEE CAN BE TRANSPORTED  
2 WITHOUT SUFFERING DETRIMENTAL CONSEQUENCES OR AGGRAVATING THE  
3 COVERED PERSON'S OR ENROLLEE'S CONDITION, THE COVERED PERSON OR  
4 ENROLLEE MAY BE RELOCATED TO ANOTHER FACILITY TO RECEIVE  
5 CONTINUED CARE AND TREATMENT AS NECESSARY.

6 (B) FOR EMERGENCY SERVICES RENDERED BY A LICENSED EMERGENCY  
7 MEDICAL SERVICES AGENCY, AS DEFINED IN 35 PA.C.S. § 8103  
8 (RELATING TO DEFINITIONS), THAT HAS THE ABILITY TO TRANSPORT  
9 PATIENTS OR IS PROVIDING AND BILLING FOR EMERGENCY SERVICES  
10 UNDER AN AGREEMENT WITH AN EMERGENCY MEDICAL SERVICES AGENCY  
11 THAT HAS THAT ABILITY, THE INSURER OR MA OR CHIP MANAGED CARE  
12 PLAN MAY NOT DENY A CLAIM FOR PAYMENT SOLELY BECAUSE THE  
13 ENROLLEE DID NOT REQUIRE TRANSPORT OR REFUSED TO BE TRANSPORTED.  
14 THE REQUIREMENTS OF SUBSECTION (A.1) DO NOT APPLY TO A LICENSED <--  
15 EMERGENCY MEDICAL SERVICES AGENCY UNDER THIS PARAGRAPH.

16 (C) FOR EMERGENCY SERVICES PROVIDED TO [MEDICAL ASSISTANCE  
17 PARTICIPANTS] MA OR CHIP MANAGED CARE PLAN ENROLLEES, THE  
18 FOLLOWING PROVISIONS SHALL APPLY:

19 (1) THE PROVISIONS OF SUBSECTION (B) SHALL APPLY TO THE SAME  
20 SERVICES PROVIDED TO MEDICAL ASSISTANCE PARTICIPANTS UNDER  
21 ARTICLE IV OF THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS  
22 THE HUMAN SERVICES CODE.

23 (2) PAYMENT FOR THE SERVICES SHALL BE IN ACCORDANCE WITH THE  
24 CURRENT MA OR CHIP MANAGED CARE CONTRACTED RATES.

25 (3) SUFFICIENT FUNDS SHALL BE APPROPRIATED EACH FISCAL YEAR  
26 FOR PAYMENT OF THE SERVICES.

27 [(D) THE PROVISIONS OF SUBSECTION (B) SHALL APPLY TO ALL  
28 GROUP AND INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE POLICIES  
29 ISSUED BY A LICENSED HEALTH INSURER.]

30 SECTION 2117. CONTINUITY OF CARE.--(A) EXCEPT AS PROVIDED



1 UNDER SUBSECTION (B), IF [A] AN INSURER OR MA OR CHIP MANAGED  
2 CARE PLAN INITIATES TERMINATION OF ITS CONTRACT WITH A  
3 PARTICIPATING HEALTH CARE PROVIDER, [AN] A COVERED PERSON OR  
4 ENROLLEE MAY CONTINUE AN ONGOING COURSE OF TREATMENT WITH THAT  
5 HEALTH CARE PROVIDER AT THE COVERED PERSON'S OR ENROLLEE'S  
6 OPTION FOR A TRANSITIONAL PERIOD OF UP TO SIXTY (60) DAYS FROM  
7 THE DATE THE COVERED PERSON OR ENROLLEE WAS NOTIFIED BY THE  
8 INSURER OR MA OR CHIP MANAGED CARE PLAN OF THE TERMINATION OR  
9 PENDING TERMINATION. THE INSURER OR MA OR CHIP MANAGED CARE  
10 PLAN, IN CONSULTATION WITH THE COVERED PERSON OR ENROLLEE AND  
11 THE HEALTH CARE PROVIDER, MAY EXTEND THE TRANSITIONAL PERIOD IF  
12 DETERMINED TO BE CLINICALLY APPROPRIATE. IN THE CASE OF [AN] A  
13 COVERED PERSON OR ENROLLEE IN THE SECOND OR THIRD TRIMESTER OF  
14 PREGNANCY AT THE TIME OF NOTICE OF THE TERMINATION OR PENDING  
15 TERMINATION, THE TRANSITIONAL PERIOD SHALL EXTEND THROUGH  
16 POSTPARTUM CARE RELATED TO THE DELIVERY. ANY HEALTH CARE SERVICE  
17 PROVIDED UNDER THIS SECTION SHALL BE COVERED BY THE INSURER OR  
18 MA OR CHIP MANAGED CARE PLAN UNDER THE SAME TERMS AND CONDITIONS  
19 AS APPLICABLE FOR PARTICIPATING HEALTH CARE PROVIDERS.

20 (B) IF [THE] AN INSURER OR MA OR CHIP MANAGED CARE PLAN  
21 TERMINATES THE CONTRACT OF A PARTICIPATING HEALTH CARE PROVIDER  
22 FOR CAUSE, INCLUDING BREACH OF CONTRACT, FRAUD, CRIMINAL  
23 ACTIVITY OR POSING A DANGER TO [AN] A COVERED PERSON OR ENROLLEE  
24 OR THE HEALTH, SAFETY OR WELFARE OF THE PUBLIC AS DETERMINED BY  
25 THE INSURER OR MA OR CHIP MANAGED CARE PLAN, THE INSURER OR MA  
26 OR CHIP MANAGED CARE PLAN SHALL NOT BE RESPONSIBLE FOR HEALTH  
27 CARE SERVICES PROVIDED TO THE COVERED PERSON OR ENROLLEE  
28 FOLLOWING THE DATE OF TERMINATION.

29 (C) IF [THE] AN INSURER OR MA OR CHIP MANAGED CARE PLAN  
30 TERMINATES THE CONTRACT OF A PARTICIPATING PRIMARY CARE

1 PROVIDER, THE INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
2 NOTIFY EVERY COVERED PERSON OR ENROLLEE SERVED BY THAT PROVIDER  
3 OF THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S TERMINATION  
4 OF ITS CONTRACT AND SHALL REQUEST THAT THE COVERED PERSON OR  
5 ENROLLEE SELECT ANOTHER PRIMARY CARE PROVIDER.

6 (D) A NEW COVERED PERSON OR ENROLLEE MAY CONTINUE AN ONGOING  
7 COURSE OF TREATMENT WITH A NONPARTICIPATING HEALTH CARE PROVIDER  
8 FOR A TRANSITIONAL PERIOD OF UP TO SIXTY (60) DAYS FROM THE  
9 EFFECTIVE DATE OF ENROLLMENT IN A HEALTH INSURANCE POLICY OR MA  
10 OR CHIP MANAGED CARE PLAN. THE INSURER OR MA OR CHIP MANAGED  
11 CARE PLAN, IN CONSULTATION WITH THE COVERED PERSON OR ENROLLEE  
12 AND THE HEALTH CARE PROVIDER, MAY EXTEND THIS TRANSITIONAL  
13 PERIOD IF DETERMINED TO BE CLINICALLY APPROPRIATE. IN THE CASE  
14 OF A NEW COVERED PERSON OR ENROLLEE IN THE SECOND OR THIRD  
15 TRIMESTER OF PREGNANCY ON THE EFFECTIVE DATE OF ENROLLMENT, THE  
16 TRANSITIONAL PERIOD SHALL EXTEND THROUGH POSTPARTUM CARE RELATED  
17 TO THE DELIVERY. ANY HEALTH CARE SERVICE PROVIDED UNDER THIS  
18 SECTION SHALL BE COVERED BY THE HEALTH INSURANCE POLICY OR MA OR  
19 CHIP MANAGED CARE PLAN UNDER THE SAME TERMS AND CONDITIONS AS  
20 APPLICABLE FOR PARTICIPATING HEALTH CARE PROVIDERS.

21 (E) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN MAY  
22 REQUIRE A NONPARTICIPATING HEALTH CARE PROVIDER WHOSE HEALTH  
23 CARE SERVICES ARE COVERED UNDER THIS SECTION TO MEET THE SAME  
24 TERMS AND CONDITIONS AS A PARTICIPATING HEALTH CARE PROVIDER.

25 (F) NOTHING IN THIS SECTION SHALL REQUIRE [A] AN INSURER OR  
26 MA OR CHIP MANAGED CARE PLAN TO PROVIDE HEALTH CARE SERVICES  
27 THAT ARE NOT OTHERWISE COVERED UNDER THE TERMS AND CONDITIONS OF  
28 THE [PLAN] COVERED PERSON'S HEALTH INSURANCE POLICY OR AN  
29 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

30 SECTION 2121. CREDENTIALING PROCEDURES.--(A) [A] AN INSURER

1 OR MA OR CHIP MANAGED CARE PLAN SHALL ESTABLISH A CREDENTIALING  
2 PROCESS TO ENROLL QUALIFIED HEALTH CARE PROVIDERS AND CREATE AN  
3 ADEQUATE PROVIDER NETWORK. [THE PROCESS SHALL BE APPROVED BY THE  
4 DEPARTMENT AND SHALL INCLUDE WRITTEN CRITERIA AND PROCEDURES FOR  
5 INITIAL ENROLLMENT, RENEWAL, RESTRICTIONS AND TERMINATION OF  
6 CREDENTIALS FOR HEALTH CARE PROVIDERS.]

7 (A.1) AN INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
8 CREDENTIALING PROCESS SHALL BE SUBJECT TO APPROVAL BY THE  
9 DEPARTMENT AND SHALL INCLUDE WRITTEN CRITERIA AND PROCEDURES FOR  
10 AT LEAST THE FOLLOWING:

11 (1) INITIAL CREDENTIALING.

12 (2) RENEWAL OF CREDENTIALING.

13 (3) RESTRICTING AND TERMINATING THE CREDENTIALS FOR HEALTH  
14 CARE PROVIDERS.

15 (B) THE DEPARTMENT SHALL ESTABLISH CREDENTIALING STANDARDS  
16 FOR INSURERS AND MA OR CHIP MANAGED CARE PLANS. THE DEPARTMENT  
17 MAY ADOPT NATIONALLY RECOGNIZED ACCREDITING STANDARDS TO  
18 ESTABLISH THE CREDENTIALING STANDARDS FOR INSURERS AND MA OR  
19 CHIP MANAGED CARE PLANS.

20 (C) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
21 SUBMIT A REPORT TO THE DEPARTMENT REGARDING ITS CREDENTIALING  
22 PROCESS AT LEAST EVERY TWO (2) YEARS OR AS MAY OTHERWISE BE  
23 REQUIRED BY THE DEPARTMENT.

24 (D) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
25 DISCLOSE RELEVANT CREDENTIALING CRITERIA AND PROCEDURES TO  
26 HEALTH CARE PROVIDERS THAT APPLY TO PARTICIPATE OR THAT ARE  
27 PARTICIPATING IN THE INSURER'S OR MANAGED CARE PLAN'S PROVIDER  
28 NETWORK. [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
29 ALSO DISCLOSE RELEVANT CREDENTIALING CRITERIA AND PROCEDURES  
30 PURSUANT TO A COURT ORDER OR RULE. ANY INDIVIDUAL PROVIDING

1 INFORMATION DURING THE CREDENTIALING PROCESS OF [A] AN INSURER  
2 OR MA OR CHIP MANAGED CARE PLAN SHALL HAVE THE PROTECTIONS SET  
3 FORTH IN THE ACT OF JULY 20, 1974 (P.L.564, NO.193), KNOWN AS  
4 THE "PEER REVIEW PROTECTION ACT."

5 (E) NO INSURER OR MA OR CHIP MANAGED CARE PLAN [~~SHALL~~] MAY  
6 EXCLUDE OR TERMINATE A HEALTH CARE PROVIDER FROM PARTICIPATION  
7 IN THE [~~PLAN~~] INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
8 PROVIDER NETWORK DUE TO ANY OF THE FOLLOWING:

9 (1) THE HEALTH CARE PROVIDER ENGAGED IN ANY OF THE  
10 ACTIVITIES SET FORTH IN SECTION 2113(C).

11 (2) THE HEALTH CARE PROVIDER HAS A PRACTICE THAT INCLUDES A  
12 SUBSTANTIAL NUMBER OF PATIENTS WITH EXPENSIVE MEDICAL  
13 CONDITIONS.

14 (3) THE HEALTH CARE PROVIDER OBJECTS TO THE PROVISION OF OR  
15 REFUSES TO PROVIDE A HEALTH CARE SERVICE ON MORAL OR RELIGIOUS  
16 GROUNDS.

17 (F) IF [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN DENIES  
18 ENROLLMENT OR RENEWAL OF CREDENTIALS TO A HEALTH CARE PROVIDER,  
19 THE INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL PROVIDE THE  
20 HEALTH CARE PROVIDER WITH WRITTEN NOTICE OF THE DECISION. THE  
21 NOTICE SHALL INCLUDE A CLEAR RATIONALE FOR THE DECISION.

22 SECTION 2131. CONFIDENTIALITY.-- (A) [A] AN INSURER OR MA OR  
23 CHIP MANAGED CARE PLAN [~~AND A UTILIZATION REVIEW ENTITY~~] SHALL  
24 ADOPT AND MAINTAIN PROCEDURES TO ENSURE THAT ALL [~~IDENTIFIABLE~~]  
25 PROTECTED HEALTH INFORMATION REGARDING COVERED PERSON OR  
26 ENROLLEE HEALTH, DIAGNOSIS AND TREATMENT IS ADEQUATELY PROTECTED  
27 AND REMAINS CONFIDENTIAL IN COMPLIANCE WITH ALL APPLICABLE  
28 FEDERAL AND STATE LAWS AND REGULATIONS AND PROFESSIONAL ETHICAL  
29 STANDARDS.

30 (B) TO THE EXTENT [A] AN INSURER OR MA OR CHIP MANAGED CARE

1 PLAN [MAINTAINS] RECEIVES MEDICAL RECORDS RELATING TO A COVERED <--  
2 PERSON OR ENROLLEE, THE INSURER OR MA OR CHIP MANAGED CARE PLAN  
3 SHALL ADOPT AND MAINTAIN PROCEDURES TO ENSURE THAT COVERED  
4 PERSONS AND ENROLLEES HAVE TIMELY ACCESS TO THEIR MEDICAL  
5 RECORDS UPON REQUEST OF THE COVERED PERSON OR ENROLLEE, <--  
6 INCLUDING MEDICAL RECORDS PROVIDED BY A HEALTH CARE PROVIDER IN  
7 THE CONTEXT OF UTILIZATION REVIEW OR A COMPLAINT, GRIEVANCE OR  
8 ADVERSE BENEFIT DETERMINATION, UNLESS PROHIBITED BY FEDERAL OR  
9 STATE LAW OR REGULATION.

10 (C) (1) INFORMATION REGARDING [AN] A COVERED PERSON'S OR  
11 ENROLLEE'S HEALTH OR TREATMENT SHALL BE AVAILABLE TO THE COVERED  
12 PERSON OR ENROLLEE, THE COVERED PERSON'S OR ENROLLEE'S  
13 [DESIGNEE] AUTHORIZED REPRESENTATIVE OR AS NECESSARY TO PREVENT  
14 DEATH OR SERIOUS INJURY.

15 (2) NOTHING IN THIS SECTION SHALL:

16 (I) PREVENT DISCLOSURE NECESSARY TO DETERMINE COVERAGE,  
17 REVIEW COMPLAINTS [OR], GRIEVANCES OR ADVERSE BENEFIT  
18 DETERMINATIONS, CONDUCT UTILIZATION REVIEW OR FACILITATE PAYMENT  
19 OF A CLAIM.

20 (II) DENY THE DEPARTMENT[, THE INSURANCE DEPARTMENT] OR THE  
21 DEPARTMENT OF [PUBLIC WELFARE] HUMAN SERVICES ACCESS TO RECORDS  
22 FOR PURPOSES OF QUALITY ASSURANCE, INVESTIGATION OF COMPLAINTS  
23 [OR], GRIEVANCES OR ADVERSE BENEFIT DETERMINATIONS, ENFORCEMENT  
24 OR OTHER ACTIVITIES RELATED TO COMPLIANCE WITH THIS ARTICLE AND  
25 OTHER LAWS OF THIS COMMONWEALTH. RECORDS SHALL BE ACCESSIBLE  
26 ONLY TO DEPARTMENT EMPLOYEES OR AGENTS WITH DIRECT  
27 RESPONSIBILITIES UNDER THE PROVISIONS OF THIS SUBPARAGRAPH.

28 (III) DENY ACCESS TO INFORMATION NECESSARY FOR A UTILIZATION  
29 REVIEW ENTITY TO CONDUCT A REVIEW UNDER THIS ARTICLE.

30 (IV) DENY ACCESS TO THE INSURER OR MA OR CHIP MANAGED CARE

1 PLAN FOR INTERNAL QUALITY REVIEW, INCLUDING REVIEWS CONDUCTED AS  
2 PART OF THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S QUALITY  
3 OVERSIGHT PROCESS. DURING SUCH REVIEWS, COVERED PERSONS AND  
4 ENROLLEES SHALL REMAIN ANONYMOUS TO THE GREATEST EXTENT  
5 POSSIBLE.

6 (V) DENY ACCESS TO INSURERS OR MA OR CHIP MANAGED CARE  
7 PLANS, HEALTH CARE PROVIDERS AND THEIR RESPECTIVE DESIGNEES FOR  
8 THE PURPOSE OF PROVIDING PATIENT CARE MANAGEMENT, OUTCOMES  
9 IMPROVEMENT AND RESEARCH. FOR THIS PURPOSE, COVERED PERSONS AND  
10 ENROLLEES SHALL PROVIDE CONSENT AND SHALL REMAIN ANONYMOUS TO  
11 THE GREATEST EXTENT POSSIBLE.

12 (F) INFORMATION FOR COVERED  
13 PERSONS AND ENROLLEES.

14 SECTION 2136. REQUIRED DISCLOSURE.--(A) **[A]** AN INSURER OR  
15 MA OR CHIP MANAGED CARE PLAN SHALL SUPPLY EACH COVERED PERSON OR  
16 ENROLLEE AND, UPON WRITTEN REQUEST, EACH PROSPECTIVE COVERED  
17 PERSON OR ENROLLEE OR HEALTH CARE PROVIDER WITH THE FOLLOWING  
18 WRITTEN INFORMATION. SUCH INFORMATION SHALL BE EASILY  
19 UNDERSTANDABLE BY THE LAYPERSON AND SHALL INCLUDE, BUT NOT BE  
20 LIMITED TO:

21 (1) A DESCRIPTION OF COVERAGE, BENEFITS AND BENEFIT  
22 MAXIMUMS, INCLUDING BENEFIT LIMITATIONS AND EXCLUSIONS OF  
23 COVERAGE, HEALTH CARE SERVICES AND THE DEFINITION OF MEDICAL  
24 NECESSITY USED BY THE INSURER OR MA OR CHIP MANAGED CARE PLAN IN  
25 DETERMINING WHETHER THESE BENEFITS WILL BE COVERED. THE  
26 FOLLOWING STATEMENT OR SUBSTANTIALLY SIMILAR STATEMENT SHALL BE  
27 INCLUDED IN ALL MARKETING MATERIALS IN BOLDFACE TYPE:

28 FOR INSURERS: THIS **[MANAGED CARE PLAN]** HEALTH INSURANCE  
29 POLICY MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES. READ YOUR  
30 CONTRACT OR MEMBER HANDBOOK CAREFULLY TO DETERMINE WHICH

1 HEALTH CARE SERVICES ARE COVERED.  
2 FOR MA OR CHIP MANAGED CARE PLANS: YOUR MANAGED CARE PLAN MAY  
3 NOT COVER ALL YOUR HEALTH CARE EXPENSES. READ YOUR MEMBER  
4 HANDBOOK CAREFULLY TO DETERMINE WHICH HEALTH CARE SERVICES  
5 ARE COVERED.

6 THE NOTICE SHALL BE FOLLOWED BY A TELEPHONE NUMBER TO CONTACT  
7 THE INSURER OR MA OR CHIP MANAGED CARE PLAN.

8 (2) A DESCRIPTION OF ALL NECESSARY PRIOR AUTHORIZATIONS OR  
9 OTHER REQUIREMENTS FOR NONEMERGENCY HEALTH CARE SERVICES AS  
10 REQUIRED BY SECTION 2155.

11 (3) AN EXPLANATION OF [AN] A COVERED PERSON'S OR ENROLLEE'S  
12 FINANCIAL RESPONSIBILITY FOR PAYMENT OF PREMIUMS, COINSURANCE,  
13 COPAYMENTS, DEDUCTIBLES AND OTHER CHARGES, ANNUAL LIMITS ON [AN]  
14 A COVERED PERSON'S OR ENROLLEE'S FINANCIAL RESPONSIBILITY AND  
15 CAPS ON PAYMENTS FOR HEALTH CARE SERVICES PROVIDED UNDER THE  
16 [PLAN] HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE  
17 DEPARTMENT OF HUMAN SERVICES.

18 (4) AN EXPLANATION OF [AN] A COVERED PERSON'S OR ENROLLEE'S  
19 FINANCIAL RESPONSIBILITY FOR PAYMENT WHEN A HEALTH CARE SERVICE  
20 IS PROVIDED BY A NONPARTICIPATING HEALTH CARE PROVIDER, WHEN A  
21 HEALTH CARE SERVICE IS PROVIDED BY ANY HEALTH CARE PROVIDER  
22 WITHOUT REQUIRED AUTHORIZATION OR WHEN THE CARE RENDERED IS NOT  
23 COVERED [BY THE PLAN] UNDER THE HEALTH INSURANCE POLICY OR BY AN  
24 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

25 (5) A DESCRIPTION OF HOW THE INSURER OR MA OR CHIP MANAGED  
26 CARE PLAN ADDRESSES THE NEEDS OF NON-ENGLISH-SPEAKING COVERED  
27 PERSONS OR ENROLLEES.

28 (6) A NOTICE OF MAILING ADDRESSES AND TELEPHONE NUMBERS  
29 NECESSARY TO ENABLE [AN] A COVERED PERSON OR ENROLLEE TO OBTAIN  
30 APPROVAL OR AUTHORIZATION OF A HEALTH CARE SERVICE OR OTHER

1 INFORMATION REGARDING THE HEALTH INSURANCE POLICY OR SERVICES  
2 COVERED BY THE MA OR CHIP MANAGED CARE PLAN.

3 (7) A SUMMARY OF THE INSURER'S OR MA OR CHIP MANAGED CARE  
4 PLAN'S UTILIZATION REVIEW POLICIES AND PROCEDURES.

5 (8) A SUMMARY OF ALL COMPLAINT [AND], GRIEVANCE OR ADVERSE  
6 BENEFIT DETERMINATION PROCEDURES USED TO RESOLVE DISPUTES  
7 BETWEEN THE INSURER OR MA OR CHIP MANAGED CARE PLAN AND [AN] A  
8 COVERED PERSON OR ENROLLEE OR A HEALTH CARE PROVIDER, INCLUDING:

9 (I) THE PROCEDURE TO FILE A COMPLAINT [OR], GRIEVANCE OR  
10 ADVERSE BENEFIT DETERMINATION APPEAL AS SET FORTH IN THIS  
11 ARTICLE, INCLUDING A TOLL-FREE TELEPHONE NUMBER TO OBTAIN  
12 INFORMATION REGARDING THE FILING AND STATUS OF A COMPLAINT [OR],  
13 GRIEVANCE OR ADVERSE BENEFIT DETERMINATION.

14 (II) THE RIGHT TO APPEAL A DECISION RELATING TO A COMPLAINT  
15 [OR], GRIEVANCE OR ADVERSE BENEFIT DETERMINATION.

16 (III) THE COVERED PERSON'S OR ENROLLEE'S RIGHT TO DESIGNATE  
17 A REPRESENTATIVE TO PARTICIPATE IN THE COMPLAINT [OR], GRIEVANCE  
18 OR ADVERSE BENEFIT DETERMINATION PROCESS AS SET FORTH IN THIS  
19 ARTICLE.

20 (IV) A NOTICE THAT ALL [DISPUTES] DECISIONS INVOLVING DENIAL  
21 OF PAYMENT FOR A HEALTH CARE SERVICE WILL BE MADE BY QUALIFIED  
22 PERSONNEL WITH EXPERIENCE IN THE SAME OR SIMILAR SCOPE OF  
23 PRACTICE AND THAT ALL NOTICES OF DECISIONS WILL INCLUDE  
24 INFORMATION REGARDING THE BASIS FOR THE DETERMINATION.

25 (9) A DESCRIPTION OF THE PROCEDURE FOR PROVIDING EMERGENCY  
26 SERVICES TWENTY-FOUR (24) HOURS A DAY. THE DESCRIPTION SHALL  
27 INCLUDE:

28 (I) A DEFINITION OF EMERGENCY SERVICES AS SET FORTH IN THIS  
29 ARTICLE.

30 (II) NOTICE THAT EMERGENCY SERVICES ARE NOT SUBJECT TO PRIOR



1 APPROVAL.

2 (III) THE COVERED PERSON'S OR ENROLLEE'S FINANCIAL AND OTHER  
3 RESPONSIBILITIES REGARDING EMERGENCY SERVICES, INCLUDING THE  
4 RECEIPT OF THESE SERVICES OUTSIDE THE INSURER'S OR MA OR CHIP  
5 MANAGED CARE PLAN'S SERVICE AREA.

6 (10) A DESCRIPTION OF THE PROCEDURES FOR COVERED PERSONS OR  
7 ENROLLEES TO SELECT A PARTICIPATING HEALTH CARE PROVIDER,  
8 INCLUDING HOW TO DETERMINE WHETHER A PARTICIPATING HEALTH CARE  
9 PROVIDER IS ACCEPTING NEW [ENROLLEES] PATIENTS.

10 (11) A DESCRIPTION OF THE PROCEDURES FOR CHANGING PRIMARY  
11 CARE PROVIDERS AND SPECIALISTS.

12 (12) A DESCRIPTION OF THE PROCEDURES BY WHICH [AN] A COVERED  
13 PERSON OR ENROLLEE MAY OBTAIN A REFERRAL TO A HEALTH CARE  
14 PROVIDER OUTSIDE THE HEALTH INSURANCE POLICY'S OR MA OR CHIP  
15 MANAGED CARE PLAN'S PROVIDER NETWORK WHEN THAT PROVIDER NETWORK  
16 DOES NOT INCLUDE A HEALTH CARE PROVIDER WITH APPROPRIATE  
17 TRAINING AND EXPERIENCE TO MEET THE HEALTH CARE SERVICE NEEDS OF  
18 [AN] A COVERED PERSON OR ENROLLEE.

19 (13) A DESCRIPTION OF THE PROCEDURES THAT [AN] A COVERED  
20 PERSON OR ENROLLEE WITH A LIFE-THREATENING, DEGENERATIVE OR  
21 DISABLING DISEASE OR CONDITION SHALL FOLLOW AND SATISFY TO BE  
22 ELIGIBLE FOR EITHER OF THE FOLLOWING:

23 (I) [A] A STANDING REFERRAL TO A SPECIALIST WITH CLINICAL  
24 EXPERTISE IN TREATING THE DISEASE OR CONDITION[; OR].

25 (II) [THE] THE DESIGNATION OF A SPECIALIST TO PROVIDE AND  
26 COORDINATE THE COVERED PERSON'S OR ENROLLEE'S PRIMARY AND  
27 SPECIALTY CARE.

28 (14) A LIST BY SPECIALTY OF THE NAME, ADDRESS AND TELEPHONE  
29 NUMBER OF ALL [PARTICIPATING] HEALTH CARE PROVIDERS  
30 PARTICIPATING IN THE PROVIDER NETWORK FOR THE HEALTH INSURANCE

1 POLICY OR MA OR CHIP MANAGED CARE PLAN. THE LIST MAY BE A  
2 SEPARATE DOCUMENT AND SHALL BE UPDATED AT LEAST [ANNUALLY.] ONCE  
3 EVERY 90 DAYS OR MORE FREQUENTLY AS MAY BE REQUIRED BY FEDERAL  
4 OR STATE LAW, INCLUDING SECTION 2799A-5 OF THE PUBLIC HEALTH  
5 SERVICE ACT (58 STAT. 682, 42 U.S.C. § 201 ET SEQ.)

6 (15) A LIST OF THE INFORMATION AVAILABLE TO COVERED PERSONS  
7 OR ENROLLEES OR PROSPECTIVE COVERED PERSONS OR ENROLLEES, UPON  
8 WRITTEN REQUEST, UNDER SUBSECTION (B).

9 (B) EACH INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL, UPON  
10 WRITTEN REQUEST OF [AN] A COVERED PERSON OR ENROLLEE OR  
11 PROSPECTIVE COVERED PERSON OR ENROLLEE, PROVIDE THE FOLLOWING  
12 WRITTEN INFORMATION:

13 (1) A LIST OF THE NAMES, BUSINESS ADDRESSES AND OFFICIAL  
14 POSITIONS OF THE MEMBERSHIP OF THE BOARD OF DIRECTORS OR  
15 OFFICERS OF THE INSURER OR MA OR CHIP MANAGED CARE PLAN.

16 (2) THE PROCEDURES ADOPTED TO PROTECT THE CONFIDENTIALITY OF  
17 MEDICAL RECORDS AND OTHER COVERED PERSON OR ENROLLEE  
18 INFORMATION.

19 (3) A DESCRIPTION OF THE CREDENTIALING PROCESS FOR HEALTH  
20 CARE PROVIDERS.

21 (4) A LIST OF THE PARTICIPATING HEALTH CARE PROVIDERS  
22 AFFILIATED WITH PARTICIPATING HOSPITALS.

23 (5) WHETHER A SPECIFICALLY IDENTIFIED DRUG IS INCLUDED OR  
24 EXCLUDED FROM COVERAGE.

25 (6) A DESCRIPTION OF THE PROCESS BY WHICH A HEALTH CARE  
26 PROVIDER CAN PRESCRIBE SPECIFIC DRUGS, DRUGS USED FOR AN OFF-  
27 LABEL PURPOSE, BIOLOGICALS AND MEDICATIONS NOT INCLUDED IN THE  
28 DRUG FORMULARY FOR PRESCRIPTION DRUGS [OR BIOLOGICALS] WHEN THE  
29 FORMULARY'S EQUIVALENT HAS BEEN INEFFECTIVE IN THE TREATMENT OF  
30 THE COVERED PERSON'S OR ENROLLEE'S DISEASE OR IF THE DRUG CAUSES

1 OR IS REASONABLY EXPECTED TO CAUSE ADVERSE OR HARMFUL REACTIONS  
2 TO THE COVERED PERSON OR ENROLLEE.

3 (7) A DESCRIPTION OF THE PROCEDURES FOLLOWED BY THE INSURER  
4 OR MA OR CHIP MANAGED CARE PLAN TO MAKE DECISIONS ABOUT THE  
5 EXPERIMENTAL NATURE OF INDIVIDUAL DRUGS, MEDICAL DEVICES OR  
6 TREATMENTS.

7 (8) A SUMMARY OF THE METHODOLOGIES USED BY THE INSURER OR MA  
8 OR CHIP MANAGED CARE PLAN TO REIMBURSE FOR HEALTH CARE SERVICES.  
9 NOTHING IN THIS PARAGRAPH SHALL BE CONSTRUED TO REQUIRE  
10 DISCLOSURE OF INDIVIDUAL CONTRACTS OR THE SPECIFIC DETAILS OF  
11 ANY FINANCIAL ARRANGEMENT BETWEEN [A] AN INSURER OR MA OR CHIP  
12 MANAGED CARE PLAN AND A HEALTH CARE PROVIDER.

13 (9) A DESCRIPTION OF THE PROCEDURES USED IN THE INSURER'S OR  
14 MA OR CHIP MANAGED CARE PLAN'S QUALITY ASSURANCE PROGRAM.

15 (10) OTHER INFORMATION AS MAY BE REQUIRED BY THE DEPARTMENT  
16 OR THE INSURANCE DEPARTMENT.

17 (C) (1) AN INSURER SHALL INCLUDE A DESCRIPTION OF THE  
18 INSURER'S EXTERNAL REVIEW PROCEDURES IN OR ATTACHED TO THE  
19 POLICY, CERTIFICATE, MEMBERSHIP BOOKLET, OUTLINE OF COVERAGE OR  
20 OTHER EVIDENCE OF COVERAGE THE INSURER PROVIDES TO COVERED  
21 PERSONS, INCLUDING WHETHER THE INSURER HAS COMPLIED WITH THE <--  
22 SURPRISE BILLING AND COST SHARING PROTECTIONS UNDER THE NO-  
23 SURPRISES ACT (PUB. L. 116 260, DIV. BB, TITLE I, 134 STAT.  
24 2758).

25 (2) THE DISCLOSURE REQUIRED BY PARAGRAPH (1) SHALL BE IN A  
26 FORMAT AS PRESCRIBED BY THE DEPARTMENT.

27 (3) THE DESCRIPTION OF PROCEDURES REQUIRED UNDER SUBSECTION  
28 (A) (C) (1) SHALL INCLUDE: <--

29 (I) A STATEMENT THAT INFORMS THE COVERED PERSON OF THE RIGHT  
30 TO FILE A REQUEST FOR EXTERNAL REVIEW OF AN ADVERSE BENEFIT

1 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, INCLUDING  
2 A REQUEST REGARDING WHETHER THE INSURER HAS COMPLIED WITH THE <--  
3 SURPRISE BILLING AND COST SHARING PROTECTIONS UNDER THE NO  
4 ~~SURPRISE ACT~~ SURPRISES ACT (PUBLIC LAW 116-260, DIV. BB, TITLE <--  
5 I, 134 STAT. 2758).

6 (II) THE TELEPHONE NUMBER AND ADDRESS OF THE DEPARTMENT.

7 (III) A STATEMENT THAT, WHEN FILING A REQUEST FOR AN  
8 EXTERNAL REVIEW, THE COVERED PERSON BENEFIT IS REQUIRED TO <--  
9 AUTHORIZE THE RELEASE OF MEDICAL RECORDS OF THE COVERED PERSON  
10 THAT MAY BE REQUIRED TO BE REVIEWED FOR THE PURPOSE OF REACHING  
11 A DECISION ON THE EXTERNAL REVIEW.

12 (IV) AN EXPLANATION THAT EXTERNAL REVIEW IS AVAILABLE WHEN  
13 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
14 DETERMINATION INVOLVES AN ISSUE OF MEDICAL NECESSITY,  
15 APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR  
16 EFFECTIVENESS.

17 SECTION 2. SECTION 2141 OF THE ACT IS AMENDED TO READ:

18 SECTION 2141. INTERNAL COMPLAINT PROCESS FOR COVERED  
19 PERSONS.-- (A) [A MANAGED CARE PLAN] AN INSURER SHALL ESTABLISH  
20 AND MAINTAIN AN INTERNAL COMPLAINT PROCESS WITH TWO LEVELS OF  
21 REVIEW BY WHICH [AN ENROLLEE] A COVERED PERSON OR THE COVERED  
22 PERSON'S AUTHORIZED REPRESENTATIVE SHALL BE ABLE TO FILE A  
23 COMPLAINT [REGARDING A PARTICIPATING HEALTH CARE PROVIDER OR THE  
24 COVERAGE, OPERATIONS OR MANAGEMENT POLICIES OF THE MANAGED CARE  
25 PLAN].

26 (B) THE COMPLAINT PROCESS SHALL CONSIST OF AN INITIAL REVIEW  
27 TO INCLUDE ALL OF THE FOLLOWING:

28 (1) A REVIEW BY AN INITIAL REVIEW COMMITTEE CONSISTING OF  
29 ONE OR MORE EMPLOYEES OF THE [MANAGED CARE PLAN] INSURER.

30 (2) THE ALLOWANCE OF A WRITTEN OR ORAL COMPLAINT.

1 (3) THE ALLOWANCE OF WRITTEN DATA OR OTHER INFORMATION.

2 (4) A REVIEW OR INVESTIGATION OF THE COMPLAINT WHICH SHALL  
3 BE COMPLETED WITHIN THIRTY (30) DAYS OF RECEIPT OF THE  
4 COMPLAINT.

5 (5) A WRITTEN NOTIFICATION TO THE [ENROLLEE] COVERED PERSON  
6 REGARDING THE DECISION OF THE INITIAL REVIEW COMMITTEE WITHIN  
7 FIVE (5) BUSINESS DAYS OF THE DECISION. NOTICE SHALL INCLUDE THE  
8 BASIS FOR THE DECISION AND THE PROCEDURE TO FILE A REQUEST FOR A  
9 SECOND LEVEL REVIEW OF THE DECISION OF THE INITIAL REVIEW  
10 COMMITTEE.

11 (C) THE COMPLAINT PROCESS SHALL INCLUDE A SECOND LEVEL  
12 REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

13 (1) A REVIEW OF THE DECISION OF THE INITIAL REVIEW COMMITTEE  
14 BY A SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR MORE  
15 INDIVIDUALS WHO DID NOT PARTICIPATE IN THE INITIAL REVIEW. AT  
16 LEAST ONE THIRD OF THE SECOND LEVEL REVIEW COMMITTEE SHALL NOT  
17 BE EMPLOYED BY THE [MANAGED CARE PLAN] INSURER.

18 (2) A WRITTEN NOTIFICATION TO THE [ENROLLEE] COVERED PERSON  
19 OF THE RIGHT TO APPEAR BEFORE THE SECOND LEVEL REVIEW COMMITTEE.

20 (3) A REQUIREMENT THAT THE SECOND LEVEL REVIEW BE COMPLETED  
21 WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF A REQUEST FOR SUCH  
22 REVIEW.

23 (4) A WRITTEN NOTIFICATION TO THE [ENROLLEE] COVERED PERSON  
24 REGARDING THE DECISION OF THE SECOND LEVEL REVIEW COMMITTEE  
25 WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. THE NOTICE SHALL  
26 INCLUDE THE BASIS FOR THE DECISION AND THE PROCEDURE FOR  
27 APPEALING THE DECISION TO THE DEPARTMENT [OR THE INSURANCE  
28 DEPARTMENT].

29 SECTION 3. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

30 SECTION 2141.1. INTERNAL COMPLAINT PROCESS FOR ENROLLEES.--

1 (A) AN MA OR CHIP MANAGED CARE PLAN SHALL ESTABLISH AND  
2 MAINTAIN AN INTERNAL COMPLAINT PROCESS BY WHICH AN ENROLLEE OR  
3 THE ENROLLEE'S AUTHORIZED REPRESENTATIVE SHALL BE ABLE TO FILE A  
4 COMPLAINT.

5 (B) THE COMPLAINT PROCESS SHALL CONSIST OF A REVIEW TO  
6 INCLUDE ALL OF THE FOLLOWING:

7 (1) A REVIEW BY A REVIEW COMMITTEE CONSISTING OF ONE OR MORE  
8 EMPLOYES OF THE MA OR CHIP MANAGED CARE PLAN.

9 (2) THE ALLOWANCE OF A WRITTEN OR ORAL COMPLAINT.

10 (3) THE ALLOWANCE OF WRITTEN DATA OR OTHER INFORMATION.

11 (4) WRITTEN NOTIFICATION TO THE ENROLLEE OF THE DECISION OF  
12 THE REVIEW COMMITTEE WITHIN THIRTY (30) DAYS OF RECEIPT OF THE  
13 COMPLAINT, UNLESS THE TIME FRAME FOR DECIDING THE COMPLAINT HAS  
14 BEEN EXTENDED BY UP TO FOURTEEN (14) DAYS AT THE REQUEST OF THE  
15 ENROLLEE.

16 (5) THE WRITTEN NOTIFICATION OF THE DECISION SHALL INCLUDE  
17 THE BASIS FOR THE DECISION AND THE PROCEDURE TO FILE A REQUEST  
18 FOR A SECOND LEVEL REVIEW OF THE DECISION OF THE REVIEW  
19 COMMITTEE, EXCEPT AS PROVIDED IN PARAGRAPH (6).

20 (6) THE WRITTEN NOTIFICATION OF THE DECISION SHALL INCLUDE  
21 THE BASIS FOR THE DECISION AND THE PROCEDURE TO FILE AN APPEAL  
22 OF A COMPLAINT IF THE COMPLAINT IS ABOUT ONE OF THE FOLLOWING:

23 (I) A DENIAL BECAUSE THE SERVICE OR ITEM IS NOT A COVERED  
24 SERVICE.

25 (II) THE FAILURE OF THE MA OR CHIP MANAGED CARE PLAN TO MEET  
26 THE REQUIRED TIME FRAMES FOR PROVIDING A SERVICE OR ITEM IN A  
27 TIMELY MANNER.

28 (III) THE FAILURE OF THE MA OR CHIP MANAGED CARE PLAN TO  
29 DECIDE A COMPLAINT OR GRIEVANCE WITHIN THE REQUIRED TIME FRAMES.

30 (IV) A DENIAL OF PAYMENT BY THE MA OR CHIP MANAGED CARE PLAN

1 AFTER THE SERVICE OR ITEM HAS BEEN DELIVERED BECAUSE THE SERVICE  
2 OR ITEM WAS PROVIDED BY A HEALTH CARE PROVIDER NOT ENROLLED IN  
3 THE MEDICAL ASSISTANCE PROGRAM.

4 (V) A DENIAL OF PAYMENT BY THE MA OR CHIP MANAGED CARE PLAN  
5 AFTER THE SERVICE OR ITEM HAS BEEN DELIVERED BECAUSE THE SERVICE  
6 OR ITEM PROVIDED IS NOT A COVERED SERVICE OR ITEM FOR THE  
7 ENROLLEE.

8 (VI) A DENIAL OF AN ENROLLEE'S REQUEST TO DISPUTE A  
9 FINANCIAL LIABILITY.

10 (C) FOR ALL COMPLAINTS EXCEPT COMPLAINTS LISTED IN  
11 SUBSECTION (B) (6), THE COMPLAINT PROCESS SHALL INCLUDE A SECOND  
12 LEVEL REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

13 (1) A REVIEW OF THE DECISION OF THE REVIEW COMMITTEE BY A  
14 SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR MORE  
15 INDIVIDUALS WHO DID NOT PARTICIPATE IN THE INITIAL REVIEW. AT  
16 LEAST ONE-THIRD OF THE SECOND LEVEL REVIEW COMMITTEE SHALL NOT  
17 BE EMPLOYED BY THE MA OR CHIP MANAGED CARE PLAN.

18 (2) A WRITTEN NOTIFICATION TO THE ENROLLEE OF THE RIGHT TO  
19 APPEAR BEFORE THE SECOND LEVEL REVIEW COMMITTEE.

20 (3) A WRITTEN NOTIFICATION TO THE ENROLLEE OF THE DECISION  
21 OF THE SECOND LEVEL REVIEW COMMITTEE WITHIN FORTY-FIVE (45) DAYS  
22 OF RECEIPT OF THE SECOND LEVEL COMPLAINT, WHICH SHALL INCLUDE  
23 THE BASIS FOR THE DECISION AND THE PROCEDURE FOR APPEALING THE  
24 DECISION TO THE DEPARTMENT.

25 SECTION 4. SECTIONS 2142 AND 2143, SUBDIVISION (H) HEADING  
26 OF ARTICLE XXI AND SECTIONS 2151 AND 2152 OF THE ACT ARE AMENDED  
27 TO READ:

28 SECTION 2142. APPEAL OF COMPLAINT ~~OR ADMINISTRATIVE ADVERSE~~ <--  
29 ~~BENEFIT DETERMINATION DENIAL.~~-- [(A) AN ENROLLEE SHALL HAVE <--  
30 FIFTEEN (15) DAYS FROM RECEIPT OF THE NOTICE OF THE DECISION

1 FROM THE SECOND LEVEL REVIEW COMMITTEE TO APPEAL THE DECISION TO  
2 THE DEPARTMENT OR THE INSURANCE DEPARTMENT, AS APPROPRIATE.

3 (B) ALL RECORDS FROM THE INITIAL REVIEW AND SECOND LEVEL  
4 REVIEW SHALL BE TRANSMITTED TO THE APPROPRIATE DEPARTMENT IN THE  
5 MANNER PRESCRIBED. THE ENROLLEE, THE HEALTH CARE PROVIDER OR THE  
6 MANAGED CARE PLAN MAY SUBMIT ADDITIONAL MATERIALS RELATED TO THE  
7 COMPLAINT.]

8 ~~(A) THE FOLLOWING SHALL APPLY:~~ <--

9 ~~(1) A COVERED PERSON MAY APPEAL A DECISION ABOUT THE~~  
10 ~~COVERAGE, OPERATIONS OR MANAGEMENT POLICIES OF AN INSURER, OTHER~~  
11 ~~THAN DECISIONS THAT ARE ADVERSE BENEFIT DETERMINATIONS.~~

12 ~~(2) AN ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE~~  
13 ~~SHALL HAVE FIFTEEN (15) DAYS FROM RECEIPT OF THE NOTICE OF~~  
14 ~~DECISION TO APPEAL THE DECISION TO THE DEPARTMENT IF THE SUBJECT~~  
15 ~~OF THE COMPLAINT IS LISTED IN SECTION 2141.1(B)(6).~~

16 ~~(3) A COVERED PERSON OR ENROLLEE, OR COVERED PERSON'S OR~~  
17 ~~ENROLLEE'S AUTHORIZED REPRESENTATIVE, SHALL HAVE FIFTEEN (15)~~  
18 ~~DAYS FROM RECEIPT OF THE NOTICE OF THE DECISION FROM THE SECOND~~  
19 ~~LEVEL REVIEW COMMITTEE TO APPEAL THE DECISION TO THE DEPARTMENT.~~

20 ~~(4) ALL RECORDS FROM THE REVIEW SHALL BE TRANSMITTED TO THE~~  
21 ~~DEPARTMENT IN THE MANNER PRESCRIBED. THE COVERED PERSON,~~  
22 ~~ENROLLEE, HEALTH CARE PROVIDER OR INSURER OR MA OR CHIP MANAGED~~  
23 ~~CARE PLAN MAY SUBMIT ADDITIONAL MATERIALS RELATED TO THE~~  
24 ~~COMPLAINT.~~

25 ~~(B) (1) A COVERED PERSON SHALL HAVE FIFTEEN (15) DAYS FROM~~  
26 ~~RECEIPT OF THE NOTICE OF A DECISION ON AN ADMINISTRATIVE ADVERSE~~  
27 ~~BENEFIT DETERMINATION CONDUCTED UNDER SECTION 2161.1 TO APPEAL~~  
28 ~~THE DECISION TO THE DEPARTMENT.~~

29 ~~(2) ALL RECORDS FROM THE INTERNAL CLAIM AND APPEAL PROCEDURE~~  
30 ~~SHALL BE TRANSMITTED TO THE DEPARTMENT IN THE MANNER PRESCRIBED.~~



1 ~~THE COVERED PERSON, HEALTH CARE PROVIDER OR INSURER MAY SUBMIT~~  
2 ~~ADDITIONAL MATERIALS RELATED TO THE ADMINISTRATIVE ADVERSE~~  
3 ~~BENEFIT DETERMINATION.~~

4 (A) FOR AN APPEAL OF A COMPLAINT: <--

5 (1) IF THE SUBJECT OF THE COMPLAINT IS LISTED IN SECTION  
6 2141.1(B)(6), AN ENROLLEE OR THE ENROLLEE'S AUTHORIZED  
7 REPRESENTATIVE SHALL HAVE FIFTEEN (15) DAYS FROM RECEIPT OF THE  
8 NOTICE OF DECISION TO APPEAL THE DECISION TO THE DEPARTMENT.

9 (2) IF A SECOND LEVEL REVIEW WAS COMPLETED, A COVERED PERSON  
10 OR AN ENROLLEE, OR THE COVERED PERSON'S OR ENROLLEE'S AUTHORIZED  
11 REPRESENTATIVE, SHALL HAVE FIFTEEN (15) DAYS FROM RECEIPT OF THE  
12 NOTICE OF THE DECISION FROM THE SECOND LEVEL REVIEW COMMITTEE TO  
13 APPEAL THE DECISION TO THE DEPARTMENT.

14 (B) FOR AN APPEAL OF AN ADMINISTRATIVE DENIAL:

15 (1) A COVERED PERSON OR COVERED PERSON'S AUTHORIZED  
16 REPRESENTATIVE MAY APPEAL A DECISION ABOUT THE COVERAGE,  
17 OPERATIONS OR MANAGEMENT POLICIES OF AN INSURER, OTHER THAN  
18 DECISIONS THAT ARE ADVERSE BENEFIT DETERMINATIONS.

19 (2) A COVERED PERSON OR COVERED PERSON'S AUTHORIZED  
20 REPRESENTATIVE SHALL HAVE FIFTEEN (15) DAYS FROM RECEIPT OF THE  
21 NOTICE OF A DECISION CONDUCTED UNDER SECTION 2164 ON AN  
22 ADMINISTRATIVE DENIAL, TO APPEAL THE DECISION TO THE DEPARTMENT.

23 (B.1) ALL RECORDS FROM THE INTERNAL PROCESS FOR THE  
24 COMPLAINT OR ADMINISTRATIVE DENIAL SHALL BE TRANSMITTED TO THE  
25 DEPARTMENT IN THE MANNER PRESCRIBED. THE COVERED PERSON OR  
26 ENROLLEE, THE COVERED PERSON'S OR ENROLLEE'S AUTHORIZED  
27 REPRESENTATIVE, THE HEALTH CARE PROVIDER OR THE INSURER OR MA OR  
28 CHIP MANAGED CARE PLAN, MAY SUBMIT ADDITIONAL MATERIALS RELATED  
29 TO THE COMPLAINT OR ADMINISTRATIVE DENIAL.

30 (C) THE COVERED PERSON OR ENROLLEE MAY BE REPRESENTED BY AN

1 ATTORNEY OR OTHER INDIVIDUAL BEFORE THE [APPROPRIATE] <--  
2 DEPARTMENT.

3 (D) THE [APPROPRIATE] DEPARTMENT SHALL DETERMINE WHETHER A  
4 VIOLATION OF THIS ARTICLE HAS OCCURRED AND MAY IMPOSE ANY  
5 PENALTIES AUTHORIZED BY THIS ARTICLE.

6 SECTION 2143. COMPLAINT OR ADMINISTRATIVE ADVERSE BENEFIT <--  
7 DETERMINATION DENIAL RESOLUTION.--NOTHING IN THIS SUBDIVISION <--  
8 SHALL PREVENT THE DEPARTMENT [OR THE INSURANCE DEPARTMENT] FROM  
9 COMMUNICATING WITH THE COVERED PERSON OR ENROLLEE[,] OR THE  
10 HEALTH CARE PROVIDER [OR THE], INSURER OR MA OR CHIP MANAGED  
11 CARE PLAN AS APPROPRIATE TO ASSIST IN THE RESOLUTION OF A  
12 COMPLAINT OR ADMINISTRATIVE ADVERSE BENEFIT DETERMINATION <--  
13 DENIAL. SUCH COMMUNICATION MAY OCCUR AT ANY TIME DURING THE <--  
14 [COMPLAINT] PROCESS.

15 (H) UTILIZATION REVIEW ENTITY STANDARDS.

16 SECTION 2151. CERTIFICATION.--(A) A UTILIZATION REVIEW  
17 ENTITY MAY NOT REVIEW HEALTH CARE SERVICES DELIVERED OR PROPOSED  
18 TO BE DELIVERED IN THIS COMMONWEALTH UNLESS THE ENTITY IS  
19 CERTIFIED BY THE DEPARTMENT TO PERFORM UTILIZATION REVIEW. [A  
20 UTILIZATION REVIEW ENTITY OPERATING IN THIS COMMONWEALTH ON OR  
21 BEFORE THE EFFECTIVE DATE OF THIS ARTICLE SHALL HAVE ONE YEAR  
22 FROM THE EFFECTIVE DATE OF THIS ARTICLE TO APPLY FOR  
23 CERTIFICATION.]

24 (B) THE DEPARTMENT [SHALL] MAY GRANT CERTIFICATION TO A  
25 UTILIZATION REVIEW ENTITY THAT MEETS THE REQUIREMENTS OF THIS  
26 SECTION. CERTIFICATION SHALL BE RENEWED EVERY THREE YEARS UNLESS  
27 OTHERWISE SUBJECT TO ADDITIONAL REVIEW, SUSPENSION OR REVOCATION  
28 BY THE DEPARTMENT.

29 (C) THE DEPARTMENT MAY ADOPT A NATIONALLY RECOGNIZED  
30 ACCREDITING BODY'S STANDARDS TO CERTIFY UTILIZATION REVIEW

1 ENTITIES TO THE EXTENT THE STANDARDS MEET OR EXCEED THE  
2 STANDARDS SET FORTH IN THIS ARTICLE.

3 (D) THE DEPARTMENT MAY PRESCRIBE APPLICATION AND RENEWAL  
4 FEES FOR CERTIFICATION. THE FEES SHALL REFLECT THE  
5 ADMINISTRATIVE COSTS OF CERTIFICATION [AND SHALL BE DEPOSITED IN  
6 THE GENERAL FUND].

7 (E) [A LICENSED INSURER OR A] AN INSURER OR MA OR CHIP  
8 MANAGED CARE PLAN WITH A CERTIFICATE OF AUTHORITY SHALL COMPLY  
9 WITH THE STANDARDS AND PROCEDURES OF THIS SUBDIVISION BUT SHALL  
10 NOT BE REQUIRED TO OBTAIN SEPARATE CERTIFICATION AS A  
11 UTILIZATION REVIEW ENTITY.

12 SECTION 2152. OPERATIONAL STANDARDS.-- (A) A UTILIZATION  
13 REVIEW ENTITY SHALL DO ALL OF THE FOLLOWING:

14 (1) RESPOND TO INQUIRIES RELATING TO UTILIZATION REVIEW  
15 DETERMINATIONS BY:

16 (I) PROVIDING TOLL-FREE TELEPHONE ACCESS AT LEAST FORTY (40)  
17 HOURS PER WEEK DURING NORMAL BUSINESS HOURS;

18 (II) MAINTAINING A TELEPHONE ANSWERING SERVICE OR RECORDING  
19 SYSTEM DURING NONBUSINESS HOURS; AND

20 (III) RESPONDING TO EACH TELEPHONE CALL RECEIVED BY THE  
21 ANSWERING SERVICE OR RECORDING SYSTEM REGARDING A UTILIZATION  
22 REVIEW DETERMINATION WITHIN ONE (1) BUSINESS DAY OF THE RECEIPT  
23 OF THE CALL.

24 (2) PROTECT THE CONFIDENTIALITY OF COVERED PERSON OR  
25 ENROLLEE MEDICAL RECORDS AS SET FORTH IN SECTION 2131.

26 (3) ENSURE THAT A HEALTH CARE PROVIDER IS ABLE TO VERIFY  
27 THAT AN INDIVIDUAL REQUESTING INFORMATION ON BEHALF OF THE  
28 INSURER OR MA OR CHIP MANAGED CARE PLAN IS [A LEGITIMATE] AN  
29 AUTHORIZED REPRESENTATIVE OF THE INSURER OR MA OR CHIP MANAGED  
30 CARE PLAN.

1 (4) CONDUCT UTILIZATION REVIEWS BASED ON THE MEDICAL  
2 NECESSITY [AND], APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF  
3 CARE OR EFFECTIVENESS OF THE HEALTH CARE SERVICE BEING REVIEWED  
4 [AND PROVIDE NOTIFICATION WITHIN THE FOLLOWING TIME FRAMES:].

5 (4.1) IF PERFORMING A UTILIZATION REVIEW FOR A REQUEST FOR  
6 HEALTH CARE SERVICES FOR AN COVERED PERSON OR ENROLLEE OF AN  
7 INSURER OR MA OR CHIP MANAGED CARE PLAN, PROVIDE NOTIFICATION  
8 WITHIN THE FOLLOWING TIME FRAMES:

9 (I) A [PROSPECTIVE UTILIZATION REVIEW] PRIOR AUTHORIZATION <--  
10 DECISION SHALL BE COMMUNICATED WITHIN [TWO (2) BUSINESS DAYS OF  
11 THE RECEIPT OF ALL SUPPORTING INFORMATION REASONABLY NECESSARY  
12 TO COMPLETE THE REVIEW] THE TIME FRAME SPECIFIED IN SECTION  
13 2155.

14 (II) A CONCURRENT UTILIZATION REVIEW DECISION SHALL BE  
15 COMMUNICATED WITHIN ONE (1) BUSINESS DAY OF THE RECEIPT OF ALL  
16 SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE  
17 REVIEW.

18 (III) A RETROSPECTIVE UTILIZATION REVIEW DECISION SHALL BE  
19 COMMUNICATED WITHIN THIRTY (30) DAYS OF THE RECEIPT OF ALL  
20 SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE  
21 REVIEW.

22 (5) ENSURE THAT PERSONNEL CONDUCTING A UTILIZATION REVIEW  
23 HAVE CURRENT LICENSES IN GOOD STANDING OR OTHER REQUIRED  
24 CREDENTIALS, WITHOUT RESTRICTIONS, FROM THE APPROPRIATE AGENCY.

25 (6) PROVIDE ALL DECISIONS IN WRITING TO INCLUDE THE BASIS  
26 AND CLINICAL RATIONALE FOR THE DECISION.

27 (7) NOTIFY THE HEALTH CARE PROVIDER OF ADDITIONAL FACTS OR  
28 DOCUMENTS REQUIRED TO COMPLETE THE UTILIZATION REVIEW WITHIN  
29 [FORTY-EIGHT (48) HOURS OF RECEIPT OF THE REQUEST FOR REVIEW]  
30 THE TIME FRAMES SPECIFIED IN SECTION 2155.

1 (8) MAINTAIN A WRITTEN RECORD OF UTILIZATION REVIEW  
2 DECISIONS ADVERSE TO COVERED PERSONS OR ENROLLEES FOR NOT LESS  
3 THAN THREE (3) YEARS, INCLUDING A DETAILED JUSTIFICATION AND ALL  
4 REQUIRED NOTIFICATIONS TO THE HEALTH CARE PROVIDER AND THE  
5 COVERED PERSON OR ENROLLEE.

6 (B) COMPENSATION TO ANY PERSON OR ENTITY PERFORMING  
7 UTILIZATION REVIEW MAY NOT CONTAIN INCENTIVES, DIRECT OR  
8 INDIRECT, FOR THE PERSON OR ENTITY TO APPROVE OR DENY PAYMENT  
9 FOR THE DELIVERY OF ANY HEALTH CARE SERVICE.

10 (C) UTILIZATION REVIEW THAT RESULTS IN A DENIAL OF PAYMENT  
11 FOR A HEALTH CARE SERVICE SHALL BE MADE BY A LICENSED PHYSICIAN  
12 THAT MEETS THE QUALIFICATIONS IN SECTION ~~2155(C)~~ 2155(D), EXCEPT <--  
13 AS PROVIDED IN [SUBSECTION (D)] SUBSECTIONS (D) AND (E).

14 (D) A LICENSED PSYCHOLOGIST MAY PERFORM A UTILIZATION REVIEW  
15 FOR BEHAVIORAL HEALTH CARE SERVICES WITHIN THE PSYCHOLOGIST'S  
16 SCOPE OF PRACTICE IF THE PSYCHOLOGIST'S CLINICAL EXPERIENCE  
17 PROVIDES SUFFICIENT EXPERIENCE TO REVIEW THAT SPECIFIC  
18 BEHAVIORAL HEALTH CARE SERVICE. THE USE OF A LICENSED  
19 PSYCHOLOGIST TO PERFORM A UTILIZATION REVIEW OF A BEHAVIORAL  
20 HEALTH CARE SERVICE SHALL BE APPROVED BY THE DEPARTMENT AS PART  
21 OF THE CERTIFICATION PROCESS UNDER SECTION 2151. A LICENSED  
22 PSYCHOLOGIST SHALL NOT REVIEW THE DENIAL OF PAYMENT FOR A HEALTH  
23 CARE SERVICE INVOLVING INPATIENT CARE OR A PRESCRIPTION DRUG.

24 (E) A LICENSED DENTIST MAY PERFORM A UTILIZATION REVIEW FOR  
25 DENTAL SERVICES WITHIN THE DENTIST'S SCOPE OF PRACTICE IF THE  
26 DENTIST'S CLINICAL EXPERIENCE PROVIDES SUFFICIENT EXPERIENCE TO  
27 REVIEW THAT SPECIFIC DENTAL SERVICE. THE USE OF A LICENSED  
28 DENTIST TO PERFORM A UTILIZATION REVIEW OF A DENTAL SERVICE  
29 SHALL BE APPROVED BY THE DEPARTMENT AS PART OF THE CERTIFICATION  
30 PROCESS UNDER SECTION 2151.

1 SECTION 5. ARTICLE XXI OF THE ACT IS AMENDED BY ADDING A  
2 SUBDIVISION TO READ:

3 (H.1) UTILIZATION REVIEW STANDARDS.

4 SECTION 2153. PROVIDER PORTAL.

5 (A) ESTABLISHMENT OF PROVIDER PORTAL.--WITHIN 18 MONTHS  
6 FOLLOWING THE EFFECTIVE DATE OF THIS SECTION, AN INSURER OR MA  
7 OR CHIP MANAGED CARE PLAN SHALL ESTABLISH A PROVIDER PORTAL THAT  
8 INCLUDES, AT MINIMUM, THE FOLLOWING FEATURES:

9 (1) ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATION  
10 REQUESTS.

11 (2) ACCESS TO THE INSURER'S OR MA OR CHIP MANAGED CARE  
12 PLAN'S APPLICABLE MEDICAL POLICIES.

13 (3) INFORMATION NECESSARY TO REQUEST A PEER-TO-PEER  
14 REVIEW.

15 (4) CONTACT INFORMATION FOR THE INSURER'S OR MA OR CHIP  
16 MANAGED CARE PLAN'S RELEVANT CLINICAL OR ADMINISTRATIVE  
17 STAFF.

18 (5) FOR ANY HEALTH CARE SERVICE THAT REQUIRES PRIOR <--  
19 AUTHORIZATION SERVICE THAT IS NOT SUBJECT TO ELECTRONIC <--  
20 SUBMISSION VIA THE PROVIDER PORTAL, COPIES OF APPLICABLE  
21 SUBMISSION FORMS.

22 (6) INSTRUCTIONS FOR THE SUBMISSION OF PRIOR  
23 AUTHORIZATION REQUESTS IF THE INSURER'S OR MA OR CHIP MANAGED  
24 CARE PLAN'S PROVIDER PORTAL IS UNAVAILABLE FOR ANY REASON.

25 (B) TRAINING AND SUPPORT FOR PORTAL USE.--WITHIN SIX MONTHS  
26 FOLLOWING THE ESTABLISHMENT OF A PROVIDER PORTAL UNDER  
27 SUBSECTION (A), AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
28 MAKE AVAILABLE TO HEALTH CARE PROVIDERS AND THEIR AFFILIATED OR  
29 EMPLOYED STAFF ACCESS TO TRAINING ON THE USE OF THE INSURER'S OR  
30 MA OR CHIP MANAGED CARE PLAN'S PROVIDER PORTAL.

1 (C) REQUIRED USE OF PROVIDER PORTAL.--

2 (1) WITHIN 18 MONTHS FOLLOWING THE ESTABLISHMENT OF A  
3 PROVIDER PORTAL UNDER SUBSECTION (A), A HEALTH CARE PROVIDER  
4 SEEKING PRIOR AUTHORIZATION SHALL SUBMIT THE REQUEST VIA AN  
5 INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER PORTAL  
6 UNLESS AN EXCEPTION APPLIES.

7 (2) AN INSURER OR MA OR CHIP MANAGED CARE PLAN MAY  
8 REQUIRE A HEALTH CARE PROVIDER TO SUBMIT A PRIOR  
9 AUTHORIZATION REQUEST THROUGH THE PROVIDER PORTAL UNLESS ANY  
10 OF THE FOLLOWING EXCEPTIONS APPLIES:

11 (I) THE PORTAL IS NOT AVAILABLE AND OPERATIONAL AT  
12 THE TIME OF ATTEMPTED SUBMISSION.

13 (II) THE HEALTH CARE PROVIDER DOES NOT HAVE ACCESS  
14 TO THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
15 OPERATIONAL PROVIDER PORTAL.

16 (III) THE HEALTH CARE PROVIDER SATISFIES AN  
17 ALLOWANCE BY THE INSURER OR MA OR CHIP MANAGED CARE PLAN  
18 FOR SUBMISSION OTHER THAN THROUGH THE PROVIDER PORTAL.

19 SECTION 2154. MEDICAL POLICIES AND CLINICAL REVIEW CRITERIA.

20 (A) MEDICAL POLICIES.--

21 (1) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
22 MAKE AVAILABLE ITS CURRENT MEDICAL POLICIES THROUGH THE  
23 INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S PUBLICLY  
24 ACCESSIBLE INTERNET WEBSITE AND PROVIDER PORTAL.

25 (2) EACH MEDICAL POLICY DEVELOPED BY AN INSURER OR MA OR  
26 CHIP MANAGED CARE PLAN SHALL IDENTIFY THE CLINICAL REVIEW  
27 CRITERIA USED IN THE POLICY'S DEVELOPMENT. THE INSURER OR MA  
28 OR CHIP MANAGED CARE PLAN SHALL IDENTIFY ANY THIRD-PARTY  
29 LICENSURE RESTRICTIONS PREVENTING DISCLOSURE OF ALL OR PART  
30 OF CLINICAL REVIEW CRITERIA.





1 SERVICE IN A CLINICALLY APPROPRIATE TYPE, FREQUENCY AND  
2 SETTING AND FOR A CLINICALLY APPROPRIATE DURATION.

3 (IV) REFLECT THE CURRENT MEDICAL AND SCIENTIFIC  
4 EVIDENCE REGARDING EMERGING PROCEDURES, CLINICAL  
5 GUIDELINES AND BEST PRACTICES AS ARTICULATED IN  
6 INDEPENDENT, PEER-REVIEWED MEDICAL LITERATURE.

7 (2) NOTHING IN THIS SECTION ACT SHALL REQUIRE AN INSURER <--  
8 OR MA OR CHIP MANAGED CARE PLAN TO PROVIDE COVERAGE FOR A  
9 HEALTH CARE SERVICE TO A COVERED PERSON OR ENROLLEE THAT IS  
10 OTHERWISE EXCLUDED FROM COVERAGE UNDER A HEALTH INSURANCE  
11 POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.  
12 SECTION 2155. PRIOR AUTHORIZATION REVIEW.

13 (A) GENERAL RULE.--

14 (1) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
15 MAKE A DETERMINATION RELATING TO A REQUEST FOR PRIOR <--  
16 AUTHORIZATION BASED ON THE INSURER'S OR MA OR CHIP MANAGED  
17 CARE PLAN'S REVIEW OF A PRIOR AUTHORIZATION REQUEST AND THE  
18 FOLLOWING:

19 (I) THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
20 MEDICAL POLICY.

21 (II) THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
22 ADMINISTRATIVE POLICY.

23 (III) ALL RELEVANT MEDICAL INFORMATION RELATED TO <--  
24 THE ENROLLEE OR COVERED PERSON.

25 (IV) ANY MEDICAL OR SCIENTIFIC EVIDENCE SUBMITTED BY  
26 THE REQUESTING PROVIDER.

27 (2) AT THE TIME OF REVIEW, AN INSURER OR MA OR CHIP  
28 MANAGED CARE PLAN SHALL VERIFY THE COVERED PERSON'S OR  
29 ENROLLEE'S ELIGIBILITY FOR COVERAGE UNDER THE TERMS OF THE  
30 APPLICABLE HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE

1 DEPARTMENT OF HUMAN SERVICES.

2 (3) APPEALS OF ADMINISTRATIVE ADVERSE BENEFIT- <--  
3 DETERMINATIONS DENIALS SHALL BE SUBJECT TO THE COMPLAINT <--  
4 PROCESS IN SECTION 2142.

5 (B) LIST OF SERVICES SUBJECT TO REVIEW.--AN INSURER OR MA OR  
6 CHIP MANAGED CARE PLAN SHALL MAKE AVAILABLE A LIST, POSTED IN A  
7 PUBLICLY ACCESSIBLE FORMAT AND LOCATION ON THE INSURER'S OR MA  
8 OR CHIP MANAGED CARE PLAN'S PUBLICLY ACCESSIBLE INTERNET  
9 WEBSITE, THAT INDICATES THE HEALTH CARE SERVICES FOR WHICH THE  
10 INSURER OR MA OR CHIP MANAGED CARE PLAN REQUIRES PRIOR  
11 AUTHORIZATION.

12 (C) INFORMATION SUBMISSION.--

13 (1) UPON RECEIPT AND REVIEW OF A SUBMISSION OF A PRIOR <--  
14 AUTHORIZATION REQUEST, AN INSURER, MCO MA OR CHIP MANAGED <--  
15 CARE PLAN SHALL NOTIFY THE HEALTH CARE PROVIDER SUBMITTING  
16 THE PRIOR AUTHORIZATION REQUEST OF ANY MISSING INFORMATION  
17 NEEDED BY THE INSURER, MCO MA OR CHIP MANAGED CARE PLAN TO <--  
18 MAKE A PRIOR AUTHORIZATION DETERMINATION. AN INSURER, MCO MA <--  
19 OR CHIP MANAGED CARE PLAN SHALL IDENTIFY THE MISSING  
20 INFORMATION NECESSARY TO MAKE A PRIOR AUTHORIZATION  
21 DETERMINATION WITH SUFFICIENT SPECIFICITY TO ENABLE THE  
22 HEALTH CARE PROVIDER TO SUBMIT THE MISSING INFORMATION TO <--  
23 ALLOW THE INSURER TO MAKE A DETERMINATION IN ACCORDANCE WITH  
24 THIS CHAPTER.

25 (2) IF AN INSURER OR MA OR CHIP MANAGED CARE PLAN  
26 REQUIRES A PARTICIPATING HEALTH CARE PROVIDER TO TRANSMIT  
27 MEDICAL RECORDS IN SUPPORT OF A PRIOR AUTHORIZATION REQUEST  
28 ELECTRONICALLY, AND A HEALTH CARE PROVIDER IS CAPABLE OF  
29 TRANSMITTING MEDICAL RECORDS IN SUPPORT OF A PRIOR  
30 AUTHORIZATION REQUEST ELECTRONICALLY, THE HEALTH CARE

1 PROVIDER SHALL ENSURE THAT THE INSURER OR MA OR CHIP MANAGED  
2 CARE PLAN HAS ELECTRONIC ACCESS TO THE MEDICAL RECORDS,  
3 INCLUDING ABILITY TO PRINT ANY MEDICAL RECORDS TRANSMITTED  
4 ELECTRONICALLY, SUBJECT TO APPLICABLE LAW AND THE HEALTH CARE  
5 PROVIDER'S CORPORATE POLICIES. THE INABILITY OF A HEALTH CARE  
6 PROVIDER TO PROVIDE ELECTRONIC ACCESS SHALL NOT CONSTITUTE A  
7 REASON TO DENY AN AUTHORIZATION REQUEST.

8 (D) CLINICAL KNOWLEDGE OF REVIEWER.--

9 (1) OTHER THAN AN ADMINISTRATIVE DENIAL OF A PRIOR  
10 AUTHORIZATION REQUEST, A REQUEST FOR PRIOR AUTHORIZATION MAY  
11 ONLY BE DENIED UPON REVIEW BY EITHER OF THE FOLLOWING:

12 (I) ~~A~~ A LICENSED HEALTH CARE PROVIDER WITH <--  
13 APPROPRIATE TRAINING, KNOWLEDGE OR EXPERIENCE IN THE SAME  
14 OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS  
15 ON THE HEALTH CARE SERVICE IN QUESTION--; <--  
OR

16 (II) ~~A~~ A LICENSED HEALTH CARE PROVIDER, IN <--  
17 CONSULTATION WITH AN APPROPRIATELY QUALIFIED THIRD-PARTY  
18 HEALTH CARE PROVIDER, LICENSED IN THE SAME OR SIMILAR  
19 MEDICAL SPECIALTY AS THE REQUESTING HEALTH CARE PROVIDER  
20 OR TYPE OF HEALTH CARE PROVIDER THAT TYPICALLY MANAGES  
21 THE COVERED PERSON'S OR ENROLLEE'S ASSOCIATED CONDITION, <--  
22 ~~EXCEPT THAT ANY. ANY COMPENSATION PAID TO THE CONSULTING~~ <--  
23 HEALTH CARE PROVIDER MAY NOT BE CONTINGENT UPON THE  
24 OUTCOME OF THE REVIEW.

25 (2) (RESERVED).

26 (E) PEER-TO-PEER REVIEW AVAILABLE.--IN THE CASE OF A DENIED  
27 PRIOR AUTHORIZATION REQUEST OTHER THAN AN ADMINISTRATIVE ADVERSE <--  
28 BENEFIT DETERMINATION OF A CLAIM BY A COVERED PERSON OR AN MA OR  
29 CHIP MANAGED CARE PLAN'S DENIAL OF A PRIOR AUTHORIZATION REQUEST  
30 THAT DOES NOT INVOLVE MEDICAL JUDGMENT DENIAL, AN INSURER OR MA <--

1 OR CHIP MANAGED CARE PLAN SHALL MAKE AVAILABLE TO THE REQUESTING  
2 PROVIDER A LICENSED ~~MEDICAL~~ HEALTH CARE PROFESSIONAL FOR A PEER- <--  
3 TO-PEER REVIEW DISCUSSION. THE PEER-TO-PEER REVIEWER PROVIDED BY  
4 THE INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL MEET THE  
5 STANDARDS SPECIFIED IN SUBSECTION ~~(C)~~ (D) AND HAVE AUTHORITY TO <--  
6 MODIFY OR OVERTURN THE PRIOR AUTHORIZATION DECISION. THE  
7 FOLLOWING SHALL APPLY:

8 (1) THE PROCEDURE FOR REQUESTING A PEER-TO-PEER REVIEW  
9 DISCUSSION, INCLUDING CONTACT INFORMATION FOR THE INSURER OR <--  
10 ITS UTILIZATION REVIEW ENTITY, OR MA OR CHIP MANAGED CARE  
11 PLAN OR ITS UTILIZATION REVIEW ENTITY, SHALL BE AVAILABLE ON  
12 THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S PUBLICLY  
13 ACCESSIBLE INTERNET WEBSITE ~~OR~~ AND PROVIDER PORTAL. <--

14 (2) A PROVIDER MAY REQUEST A PEER-TO-PEER REVIEW  
15 DISCUSSION:

16 (I) DURING NORMAL BUSINESS HOURS.

17 (II) OUTSIDE NORMAL BUSINESS HOURS, SUBJECT TO  
18 REASONABLE LIMITATIONS ON THE AVAILABILITY OF QUALIFIED  
19 INSURER OR MA OR CHIP MANAGED CARE PLAN OR UTILIZATION  
20 REVIEW ENTITY STAFF.

21 (F) PEER-TO-PEER PROXY.--

22 (1) A HEALTH CARE PROVIDER MAY DESIGNATE, AND AN INSURER  
23 OR MA OR CHIP MANAGED CARE PLAN SHALL ACCEPT, ANOTHER  
24 LICENSED MEMBER OF THE PROVIDER'S AFFILIATED OR EMPLOYED  
25 CLINICAL STAFF WITH KNOWLEDGE OF THE COVERED PERSON'S OR  
26 ENROLLEE'S CONDITION AND REQUESTED PROCEDURE AS A QUALIFIED  
27 PROXY FOR PURPOSES OF COMPLETING A PEER-TO-PEER DISCUSSION.

28 (2) INDIVIDUALS ELIGIBLE TO RECEIVE A PROXY DESIGNATION  
29 SHALL BE LIMITED TO LICENSED HEALTH CARE PROVIDERS WHOSE  
30 ACTUAL AUTHORITY AND SCOPE OF PRACTICE IS INCLUSIVE OF

1 PERFORMING OR PRESCRIBING THE REQUESTED HEALTH CARE SERVICE.

2 (3) AUTHORITY MAY BE ESTABLISHED THROUGH A SUPERVISING  
3 HEALTH CARE PROVIDER CONSISTENT WITH APPLICABLE STATE LAW FOR  
4 NONPHYSICIAN PRACTITIONERS.

5 (4) THE INSURER OR MA OR CHIP MANAGED CARE PLAN MUST  
6 ACCEPT AND REVIEW THE INFORMATION SUBMITTED BY OTHER MEMBERS  
7 OF A HEALTH CARE PROVIDER'S AFFILIATED OR EMPLOYED STAFF IN  
8 SUPPORT OF A PRIOR AUTHORIZATION REQUEST.

9 (5) THE INSURER OR MA OR CHIP MANAGED CARE PLAN MAY NOT  
10 LIMIT INTERACTIONS WITH AN INSURER'S OR MA OR CHIP MANAGED  
11 CARE PLAN'S CLINICAL STAFF SOLELY TO THE REQUESTING HEALTH  
12 CARE PROVIDER.

13 (G) PEER-TO-PEER TIMELINE.--

14 (1) A PEER-TO-PEER REVIEW DISCUSSION SHALL BE AVAILABLE <--  
15 TO A REQUESTING HEALTH CARE PROVIDER FROM THE TIME OF A PRIOR  
16 AUTHORIZATION DENIAL UNTIL THE INTERNAL GRIEVANCE PROCESS OR  
17 INTERNAL ADVERSE BENEFIT DETERMINATION PROCESS COMMENCES.

18 (2) IF A PEER-TO-PEER REVIEW DISCUSSION IS AVAILABLE <--  
19 PRIOR TO ~~ADJUDICATING A~~ THE INSURER OR MA OR CHIP MANAGED <--  
20 CARE PLAN MAKING A DECISION ON THE PRIOR AUTHORIZATION  
21 REQUEST, THE PEER-TO-PEER REVIEW DISCUSSION SHALL BE OFFERED <--  
22 WITHIN THE TIME LINES SPECIFIED IN THIS SUBSECTION OR  
23 SUBSECTION (H) OR (I). <--

24 (H) REVIEW TIME LINES FOR REQUESTS SUBMITTED TO AN MA OR  
25 CHIP MANAGED CARE PLAN.--

26 (1) AN MA OR CHIP MANAGED CARE PLAN'S DECISION TO  
27 APPROVE OR DENY A PRIOR AUTHORIZATION REQUEST SHALL BE <--  
28 COMMUNICATED WITHIN TWO BUSINESS DAYS OF THE RECEIPT OF ALL  
29 SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE  
30 REVIEW.

1           (2) IF AT ANY TIME AFTER REQUESTING PRIOR AUTHORIZATION  
2 THE PROVIDER DETERMINES THE ENROLLEE'S MEDICAL CONDITION  
3 REQUIRES EMERGENCY SERVICES, THE EMERGENCY SERVICES MAY BE  
4 PROVIDED UNDER SECTION 2116.

5           (3) THE FOLLOWING SHALL APPLY:

6           (I) IF A PRIOR AUTHORIZATION REQUEST IS MISSING  
7 CLINICAL INFORMATION THAT IS REASONABLY NECESSARY TO  
8 CONSTITUTE A PRIOR AUTHORIZATION REQUEST, THE MA OR CHIP  
9 MANAGED CARE PLAN SHALL NOTIFY THE HEALTH CARE PROVIDER  
10 OF THE SPECIFIC INFORMATION NECESSARY TO COMPLETE THE  
11 REVIEW AS SOON AS POSSIBLE, BUT NOT LATER THAN 48 HOURS  
12 AFTER RECEIPT OF THE PRIOR AUTHORIZATION REQUEST.

13           (II) THE REQUESTING HEALTH CARE PROVIDER OR A MEMBER  
14 OF THE REQUESTING HEALTH CARE PROVIDER'S CLINICAL OR  
15 ADMINISTRATIVE STAFF MAY SUBMIT THE SPECIFIED INFORMATION  
16 WITHIN 14 DAYS OF THE NOTIFICATION THAT CLINICAL  
17 INFORMATION IS MISSING.

18           (III) IF ADDITIONAL INFORMATION IS REQUESTED, THE MA  
19 OR CHIP MANAGED CARE PLAN SHALL COMMUNICATE A DECISION ON  
20 THE PRIOR AUTHORIZATION REQUEST WITHIN TWO BUSINESS DAYS  
21 OF RECEIVING THE ADDITIONAL INFORMATION.

22           (4) AN MA OR CHIP MANAGED CARE PLAN MAY SUPPLEMENT  
23 SUBMITTED INFORMATION BASED ON CURRENT CLINICAL RECORDS OR  
24 OTHER CURRENT MEDICAL INFORMATION FOR AN ENROLLEE AS  
25 AVAILABLE, IF THE SUPPLEMENTAL INFORMATION IS ALSO MADE  
26 AVAILABLE TO THE ENROLLEE OR HEALTH CARE PROVIDER AS PART OF  
27 THE ENROLLEE'S AUTHORIZATION CASE FILE UPON REQUEST. IN  
28 RESPONSE TO A REQUEST FOR MISSING CLINICAL INFORMATION, AN MA  
29 OR CHIP MANAGED CARE PLAN SHALL ACCEPT SUPPLEMENTAL  
30 INFORMATION FROM A MEMBER OF THE HEALTH CARE PROVIDER'S

1 CLINICAL STAFF.

2 (I) REVIEW TIME LINES FOR REQUESTS SUBMITTED TO INSURERS.-- <--  
3 DETERMINATIONS ON PRIOR AUTHORIZATION REQUESTS THAT MAY BE  
4 SUBJECT TO THE ADVERSE BENEFIT DETERMINATION PROCESSES SHALL BE  
5 IN ACCORDANCE WITH THE FOLLOWING, UNLESS OTHERWISE REQUIRED BY  
6 FEDERAL LAW OR REGULATION:

7 (1) FOR A REQUEST RELATED TO AN URGENT HEALTH CARE  
8 SERVICE:

9 (I) IF THE URGENT HEALTH CARE SERVICE HAS NOT YET  
10 BEEN INITIATED, AS SOON AS POSSIBLE, BUT NOT MORE THAN 72  
11 HOURS.

12 (II) IF RELATED TO AN ONGOING URGENT HEALTH CARE  
13 SERVICE AND THE REQUEST IS MADE AT LEAST 24 HOURS PRIOR  
14 TO REDUCTION OR TERMINATION OF THE TREATMENT, WITHIN 24  
15 HOURS.

16 (2) FOR A REQUEST INVOLVING CONCURRENT CARE OTHER THAN  
17 AS SET FORTH IN PARAGRAPH (1) (II), SUFFICIENTLY IN ADVANCE TO  
18 PERMIT AN APPEAL BEFORE REDUCTION OR TERMINATION OF THE  
19 ONGOING TREATMENT.

20 ~~(3) FOR PRIOR AUTHORIZATION REQUESTS OTHER THAN AS <--~~  
21 ~~SPECIFIED IN PARAGRAPHS (1) AND (2), WITHIN 15 DAYS. THE 15~~  
22 ~~DAY DEADLINE MAY BE EXTENDED BY THE INSURER SUBJECT TO THE~~  
23 ~~FOLLOWING LIMITATIONS:~~

24 ~~(I) UPON RECEIPT OF THE PRIOR AUTHORIZATION REQUEST,~~  
25 ~~THE INSURER PROVIDED NOTIFICATION OF MISSING INFORMATION~~  
26 ~~UNDER SECTION 2155(C) (1).~~

27 ~~(II) THE NOTIFICATION OF MISSING INFORMATION WAS~~  
28 ~~COMMUNICATED AS SOON AS POSSIBLE FOLLOWING THE SUBMISSION~~  
29 ~~OF THE PRIOR AUTHORIZATION REQUEST TO ALLOW AN~~  
30 ~~OPPORTUNITY TO RESPOND PRIOR TO THE EXPIRATION OF THE 15~~

1 ~~DAY DEADLINE WITH THE IDENTIFIED MISSING INFORMATION.~~

2 ~~(III) IF THE HEALTH CARE PROVIDER SATISFIED THE~~  
3 ~~REQUIREMENTS FOR AN INSURER TO GRANT AN EXTENSION, THE~~  
4 ~~INSURER MAY EXTEND THE DEADLINE FOR AT LEAST 45 DAYS TO~~  
5 ~~ALLOW THE PROVIDER TO RESPOND. UPON RECEIPT OF THE~~  
6 ~~MISSING INFORMATION, THE INSURER SHALL RENDER A DECISION~~  
7 ~~WITHOUT DELAY.~~

8 ~~(IV) NO INSURER SHALL UNREASONABLY DELAY OR WITHHOLD~~  
9 ~~THE SPECIFIC NOTICE OF ADDITIONAL INFORMATION NEEDED TO~~  
10 ~~COMPLETE A REVIEW OF A PRIOR AUTHORIZATION REQUEST.~~

11 ~~(V) NOTHING IN THIS PARAGRAPH SHALL REQUIRE AN~~  
12 ~~INSURER TO EXTEND THE INITIAL 15 DAY DEADLINE.~~

13 (3) FOR PRIOR AUTHORIZATION REQUESTS OTHER THAN AS <--  
14 SPECIFIED IN SUBPARAGRAPH (I), WITHIN 15 DAYS. THE FOLLOWING  
15 APPLY:

16 (I) THE 15-DAY DEADLINE MAY BE EXTENDED BY THE  
17 INSURER IF ALL OF THE FOLLOWING APPLY:

18 (A) UPON RECEIPT OF THE PRIOR AUTHORIZATION  
19 REQUEST, THE INSURER PROVIDED NOTIFICATION OF MISSING  
20 INFORMATION PURSUANT TO SUBSECTION (C) (1); AND

21 (B) THE NOTIFICATION OF MISSING INFORMATION WAS  
22 COMMUNICATED AS SOON AS POSSIBLE FOLLOWING THE  
23 SUBMISSION OF THE PRIOR AUTHORIZATION REQUEST TO  
24 ALLOW AN OPPORTUNITY TO RESPOND PRIOR TO THE  
25 EXPIRATION OF THE 15-DAY DEADLINE WITH THE IDENTIFIED  
26 MISSING INFORMATION.

27 (II) IF THE INSURER GRANTS AN EXTENSION, THE INSURER  
28 MAY EXTEND THE DEADLINE FOR AT LEAST 45 DAYS TO ALLOW THE  
29 PROVIDER TO RESPOND. UPON RECEIPT OF THE MISSING  
30 INFORMATION, THE INSURER SHALL RENDER A DECISION WITHOUT



1           DELAY.

2           (III) NO INSURER SHALL UNREASONABLY DELAY OR  
3           WITHHOLD THE SPECIFIC NOTICE OF ADDITIONAL INFORMATION  
4           NEEDED TO COMPLETE A REVIEW OF A PRIOR AUTHORIZATION  
5           REQUEST.

6           (IV) NOTHING IN THIS PARAGRAPH SHALL REQUIRE AN  
7           INSURER TO EXTEND THE INITIAL 15-DAY DEADLINE.

8           (4) FOR A REQUEST RELATED TO A PRESCRIPTION DRUG  
9           AUTHORIZATION REQUEST OR STEP THERAPY REQUEST:

10           (I) IF THE REQUEST IS URGENT, WITHIN 24 HOURS.

11           (II) IF THE REQUEST IS NOT URGENT, WITHIN TWO  
12           BUSINESS DAYS, BUT NOT MORE THAN 72 HOURS.

13           (J) CLOSELY RELATED SERVICES.--IF A HEALTH CARE PROVIDER  
14           PERFORMS A CLOSELY RELATED SERVICE, AN INSURER OR MA OR CHIP  
15           MANAGED CARE PLAN MAY NOT DENY A CLAIM FOR THE CLOSELY RELATED  
16           SERVICE FOR FAILURE OF THE HEALTH CARE PROVIDER TO SEEK OR  
17           OBTAIN PRIOR AUTHORIZATION, IF:

18           (1) THE HEALTH CARE PROVIDER NOTIFIES THE INSURER OR MA  
19           OR CHIP MANAGED CARE PLAN OF THE PERFORMANCE OF THE CLOSELY  
20           RELATED SERVICE NO LATER THAN THREE BUSINESS DAYS FOLLOWING  
21           COMPLETION OF THE SERVICE BUT PRIOR TO THE SUBMISSION OF THE  
22           CLAIM FOR PAYMENT. THE SUBMISSION OF THE NOTIFICATION SHALL  
23           INCLUDE THE SUBMISSION OF ALL RELEVANT CLINICAL INFORMATION  
24           NECESSARY FOR THE INSURER OR MA OR CHIP MANAGED CARE PLAN TO  
25           EVALUATE THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE  
26           SERVICE.

27           (2) NOTHING IN THIS SUBSECTION SHALL BE CONSTRUED TO  
28           LIMIT AN INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S  
29           RETROSPECTIVE UTILIZATION REVIEW OF MEDICAL NECESSITY AND  
30           APPROPRIATENESS OF THE CLOSELY RELATED SERVICE, NOR LIMIT THE

1 NEED FOR VERIFICATION OF THE COVERED PERSON'S OR ENROLLEE'S  
2 ELIGIBILITY FOR COVERAGE.

3 (K) NOTICE AND STATEMENT.--AN INSURER, WHEN SENDING A NOTICE <--  
4 TO A COVERED PERSON OF A DENIAL OF A REQUEST FOR PRIOR  
5 AUTHORIZATION MADE UNDER THIS SECTION, SHALL INCLUDE WITH SUCH  
6 NOTICE THE FOLLOWING STATEMENT:

7 THE STATEMENT BELOW IS REQUIRED BY  
8 PENNSYLVANIA STATE LAW.

9 ACTIONS YOU CAN TAKE AND HOW TO GET HELP.

10 YOU, OR SOMEONE ON YOUR BEHALF, RECENTLY REQUESTED  
11 APPROVAL FROM YOUR HEALTH INSURANCE PLAN FOR A HEALTH CARE  
12 SERVICE OR ITEM. YOUR HEALTH INSURANCE PLAN DENIED THE  
13 REQUEST.

14 YOU HAVE THE RIGHT TO ASK YOUR HEALTH INSURANCE PLAN TO  
15 CHANGE THIS DECISION. THIS IS CALLED AN INTERNAL APPEAL. IF  
16 THE REQUEST IS NOT APPROVED AFTER AN INTERNAL APPEAL, YOUR  
17 REQUEST MAY BE ELIGIBLE FOR A REVIEW BY AN INDEPENDENT THIRD  
18 PARTY. THIS IS CALLED AN EXTERNAL REVIEW. THE INDEPENDENT  
19 THIRD PARTY MAY CHANGE YOUR HEALTH INSURANCE PLAN'S DECISION.

20 PLEASE READ CAREFULLY THE INFORMATION YOUR HEALTH  
21 INSURANCE PLAN HAS PROVIDED WITH THIS INSERT. THIS  
22 INFORMATION EXPLAINS THE REASON(S) FOR THE HEALTH INSURANCE  
23 PLAN'S DECISION, AS WELL AS HOW TO ASK FOR AN INTERNAL APPEAL  
24 OR EXTERNAL REVIEW, INCLUDING ANY DEADLINES AND TIMING.

25 YOU SHOULD ALSO FEEL FREE TO CONTACT YOUR HEALTH  
26 INSURANCE PLAN OR THE PENNSYLVANIA INSURANCE DEPARTMENT TO  
27 HELP YOU UNDERSTAND YOUR RIGHTS AND ANSWER ANY QUESTIONS.  
28 CONTACT INFORMATION FOR BOTH YOUR HEALTH INSURANCE PLAN AND  
29 THE DEPARTMENT IS INCLUDED IN THE INFORMATION YOUR HEALTH  
30 INSURANCE PLAN HAS PROVIDED.

1 SECTION 2156. STEP THERAPY CONSIDERATIONS.

2 (A) STEP THERAPY CRITERIA.--IF AN INSURER OR MA OR CHIP  
3 MANAGED CARE PLAN HAS A MEDICAL POLICY THAT INCLUDES STEP  
4 THERAPY CRITERIA FOR A PRESCRIPTION DRUG, THE FOLLOWING APPLY:

5 (1) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL  
6 CONSIDER AS PART OF THE INSURER'S OR MA OR CHIP MANAGED CARE  
7 PLAN'S PRIOR AUTHORIZATION PROCESS A REQUEST FOR AN EXCEPTION  
8 TO THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S STEP  
9 THERAPY CRITERIA.

10 (2) A REQUEST FOR AN EXCEPTION TO AN INSURER'S OR MA OR  
11 CHIP MANAGED CARE PLAN'S STEP THERAPY CRITERIA SHALL BE BASED  
12 ON THE COVERED PERSON'S OR ENROLLEE'S INDIVIDUALIZED CLINICAL  
13 CONDITION, AND CONSIDER AT LEAST ALL OF THE FOLLOWING:

14 (I) CONTRAINDICATIONS, INCLUDING ADVERSE REACTIONS.

15 (II) CLINICAL EFFECTIVENESS OR INEFFECTIVENESS OF  
16 EACH REQUIRED PREREQUISITE PRESCRIPTION DRUG OR THERAPY.

17 (III) PAST CLINICAL OUTCOME OF EACH REQUIRED  
18 PREREQUISITE PRESCRIPTION DRUG OR THERAPY.

19 (IV) THE EXPECTED CLINICAL OUTCOMES OF THE REQUESTED  
20 PRESCRIPTION DRUG PRESCRIBED BY THE COVERED PERSON'S OR  
21 ENROLLEE'S HEALTH CARE PROVIDER. <--

22 (V) FOR COVERED PERSONS OR ENROLLEES WHO PREVIOUSLY  
23 RECEIVED HEALTH CARE COVERAGE FROM ANOTHER ENTITY,  
24 WHETHER THE COVERED PERSON OR ENROLLEE HAS ALREADY  
25 SATISFIED A STEP THERAPY PROTOCOL WITH THEIR PREVIOUS  
26 INSURER OR MA OR CHIP MANAGED CARE PLAN THAT REQUIRED  
27 TRIALS OF PRESCRIPTION DRUGS FROM EACH OF THE CLASSES  
28 THAT ARE REQUIRED BY THE CURRENT INSURER'S OR MA OR CHIP  
29 MANAGED CARE PLAN'S STEP THERAPY PROTOCOL.

30 (B) APPLICABILITY.--THE STANDARDS AND TIME LINES SPECIFIED

1 IN SECTION 2155 SHALL APPLY TO A REVIEW OF A REQUEST FOR A STEP  
2 THERAPY EXCEPTION.

3 SECTION 2157. MEDICATION-ASSISTED TREATMENT.

4 ~~(A) GENERAL RULE. AN INSURER OR MA OR CHIP MANAGED CARE~~ <--  
5 ~~PLAN SHALL MAKE AVAILABLE WITHOUT INITIAL PRIOR AUTHORIZATION~~  
6 ~~COVERAGE OF AT LEAST ONE PRESCRIPTION DRUG APPROVED BY THE~~  
7 ~~UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE IN EACH~~  
8 ~~COMPONENT OF A MEDICATION ASSISTED TREATMENT PROTOCOL.~~

9 ~~(B) PREFERRED DRUG DESIGNATION. NOTHING IN THIS SECTION~~  
10 ~~SHALL PROHIBIT AN INSURER OR MA OR CHIP MANAGED CARE PLAN FROM~~  
11 ~~DESIGNATING PREFERRED DRUGS FOR THE RELEVANT COMPONENT OF A~~  
12 ~~MEDICATION ASSISTED TREATMENT PROTOCOL WHEN MULTIPLE~~  
13 ~~PRESCRIPTION DRUGS ARE AVAILABLE, SUBJECT TO APPLICABLE MEDICAL~~  
14 ~~POLICY OR PRESCRIPTION DRUG FORMULARY INFORMATION AVAILABILITY~~  
15 ~~REQUIREMENTS.~~

16 ~~(C) SUBSEQUENT REQUESTS. WITH THE EXCEPTION OF PRIOR~~  
17 ~~AUTHORIZATION FOR INITIAL COVERAGE, NOTHING IN THIS SECTION~~  
18 ~~SHALL PROHIBIT AN INSURER OR MA OR CHIP MANAGED CARE PLAN FROM~~  
19 ~~REQUIRING PRIOR AUTHORIZATION ON SUBSEQUENT REQUESTS FOR~~  
20 ~~MEDICATION ASSISTED TREATMENT TO ENSURE ADHERENCE WITH CLINICAL~~  
21 ~~GUIDELINES.~~

22 ~~(A) MINIMUM REQUIREMENT.--AN INSURER OR MA OR CHIP MANAGED~~ <--  
23 ~~CARE PLAN SHALL MAKE AVAILABLE COVERAGE OF AT LEAST ONE~~  
24 ~~PRESCRIPTION DRUG APPROVED BY THE UNITED STATES FOOD AND DRUG~~  
25 ~~ADMINISTRATION FOR USE IN MEDICATION-ASSISTED TREATMENT FOR~~  
26 ~~OPIOID USE DISORDERS, INCLUDING COVERAGE OF AT LEAST ONE OF EACH~~  
27 ~~OF THE FOLLOWING WITHOUT PRIOR AUTHORIZATION:~~

28 ~~(1) BUPRENORPHINE/NALOXONE PRESCRIPTION DRUG COMBINATION~~  
29 ~~PRODUCT.~~

30 ~~(2) INJECTABLE AND ORAL NALTREXONE.~~

1           (3) METHADONE.

2           (B) COVERAGE AND COST TIER.--IF A MEDICATION-ASSISTED  
3 TREATMENT PRESCRIPTION DRUG SET FORTH IN SUBSECTION (A) IS  
4 COVERED AS A PHARMACY BENEFIT, THEN THE INSURER OR MA OR CHIP  
5 MANAGED CARE PLAN SHALL COVER THE PRESCRIPTION DRUG ON THE  
6 LOWEST NONPREVENTIVE COST TIER OF THE HEALTH INSURANCE POLICY OR  
7 MA OR CHIP MANAGED CARE PLAN.

8           SECTION 6. SECTIONS 2161, 2162 AND 2163 OF THE ACT ARE  
9 AMENDED TO READ:

10          SECTION 2161. INTERNAL GRIEVANCE PROCESS.-- (A) [A] AN MA OR  
11 CHIP MANAGED CARE PLAN SHALL ESTABLISH AND MAINTAIN AN INTERNAL  
12 GRIEVANCE PROCESS WITH [TWO LEVELS] ONE LEVEL OF REVIEW AND AN <--  
13 EXPEDITED INTERNAL GRIEVANCE PROCESS BY WHICH AN ENROLLEE, AN  
14 ENROLLEE'S AUTHORIZED REPRESENTATIVE OR A HEALTH CARE PROVIDER,  
15 WITH THE WRITTEN CONSENT OF THE ENROLLEE OR THE ENROLLEE'S <--  
16 AUTHORIZED REPRESENTATIVE, SHALL BE ABLE TO FILE A WRITTEN  
17 GRIEVANCE REGARDING THE DENIAL OF PAYMENT FOR A HEALTH CARE  
18 SERVICE. AN ENROLLEE OR AN ENROLLEE'S AUTHORIZED REPRESENTATIVE  
19 WHO CONSENTS TO THE FILING OF A GRIEVANCE BY A HEALTH CARE  
20 PROVIDER UNDER THIS SECTION MAY NOT FILE A SEPARATE GRIEVANCE.

21          (B) THE INTERNAL GRIEVANCE PROCESS SHALL CONSIST OF [AN <--  
22 INITIAL] A REVIEW THAT INCLUDES ALL OF THE FOLLOWING: <--

23          (1) A REVIEW BY [ONE] THREE OR MORE PERSONS SELECTED BY THE  
24 MA OR CHIP MANAGED CARE PLAN WHO DID NOT PREVIOUSLY PARTICIPATE  
25 IN THE DECISION TO DENY PAYMENT FOR THE HEALTH CARE SERVICE.

26          (2) [THE COMPLETION OF THE REVIEW WITHIN THIRTY (30) DAYS OF  
27 RECEIPT OF THE GRIEVANCE.] A WRITTEN NOTIFICATION TO THE  
28 ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OF THE  
29 DECISION OF THE REVIEW COMMITTEE WITHIN THIRTY (30) DAYS OF  
30 RECEIPT OF THE GRIEVANCE UNLESS THE TIME FRAME FOR DECIDING THE

1 GRIEVANCE HAS BEEN EXTENDED BY UP TO FOURTEEN (14) DAYS AT THE  
2 REQUEST OF THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED  
3 REPRESENTATIVE.

4 (3) [A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE  
5 PROVIDER REGARDING THE DECISION WITHIN FIVE (5) BUSINESS DAYS OF  
6 THE DECISION.] THE NOTICE SHALL INCLUDE THE BASIS AND CLINICAL  
7 RATIONALE FOR THE DECISION AND THE PROCEDURE [TO FILE A REQUEST  
8 FOR A SECOND LEVEL REVIEW OF THE DECISION] ~~FOR APPEALING THE~~ <--  
9 ~~DECISION~~ TO FILE A REQUEST FOR AN EXTERNAL REVIEW. <--

10 (C) [THE GRIEVANCE PROCESS SHALL INCLUDE A SECOND LEVEL  
11 REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

12 (1) A REVIEW OF THE DECISION ISSUED PURSUANT TO SUBSECTION  
13 (B) BY A SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR  
14 MORE PERSONS WHO DID NOT PREVIOUSLY PARTICIPATE IN ANY DECISION  
15 TO DENY PAYMENT FOR THE HEALTH CARE SERVICE.

16 (2) A WRITTEN NOTIFICATION TO THE ENROLLEE OR THE HEALTH  
17 CARE PROVIDER OF THE RIGHT TO APPEAR BEFORE THE SECOND LEVEL  
18 REVIEW COMMITTEE.

19 (3) THE COMPLETION OF THE SECOND LEVEL REVIEW WITHIN FORTY-  
20 FIVE (45) DAYS OF RECEIPT OF A REQUEST FOR SUCH REVIEW.

21 (4) A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE  
22 PROVIDER REGARDING THE DECISION OF THE SECOND LEVEL REVIEW  
23 COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. THE  
24 NOTICE SHALL INCLUDE THE BASIS AND CLINICAL RATIONALE FOR THE  
25 DECISION AND THE PROCEDURE FOR APPEALING THE DECISION.

26 (D) ANY INITIAL REVIEW OR SECOND LEVEL REVIEW CONDUCTED  
27 UNDER THIS SECTION SHALL INCLUDE A LICENSED PHYSICIAN, OR, WHERE  
28 APPROPRIATE, AN APPROVED LICENSED PSYCHOLOGIST, IN THE SAME OR  
29 SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS ON THE  
30 HEALTH CARE SERVICE.] ~~A REVIEW CONDUCTED UNDER THIS SECTION~~ <--

1 ~~SHALL INCLUDE A LICENSED PHYSICIAN OR, WHERE APPROPRIATE, AN~~  
2 ~~APPROVED LICENSED PSYCHOLOGIST OR APPROVED LICENSED DENTIST, IN~~  
3 ~~THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS~~  
4 ~~ON THE HEALTH CARE SERVICE.~~ A REVIEW CONDUCTED UNDER THIS <--  
5 SECTION SHALL INCLUDE A LICENSED PHYSICIAN OR, WHERE  
6 APPROPRIATE, A LICENSED PSYCHOLOGIST OR LICENSED DENTIST, IN THE  
7 SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS ON  
8 THE HEALTH CARE SERVICE.

9 (E) SHOULD THE ENROLLEE'S LIFE, HEALTH OR ABILITY TO REGAIN  
10 MAXIMUM FUNCTION BE IN JEOPARDY, AN EXPEDITED INTERNAL GRIEVANCE  
11 PROCESS, ~~INCLUDING AN EXPEDITED EXTERNAL GRIEVANCE PROCESS,~~ <--  
12 SHALL BE AVAILABLE WHICH SHALL INCLUDE A REQUIREMENT THAT A  
13 DECISION WITH APPROPRIATE NOTIFICATION TO THE ENROLLEE, <--  
14 ENROLLEE'S AUTHORIZED REPRESENTATIVE AND HEALTH CARE PROVIDER BE  
15 MADE WITHIN FORTY-EIGHT (48) HOURS OF THE FILING OF THE  
16 EXPEDITED GRIEVANCE.

17 SECTION 2162. EXTERNAL GRIEVANCE PROCESS.-- (A) [A] AN MA OR  
18 CHIP MANAGED CARE PLAN SHALL ESTABLISH AND MAINTAIN AN EXTERNAL  
19 GRIEVANCE PROCESS, INCLUDING AN EXPEDITED EXTERNAL GRIEVANCE <--  
20 PROCESS, BY WHICH AN ENROLLEE, AN ENROLLEE'S AUTHORIZED  
21 REPRESENTATIVE OR A HEALTH CARE PROVIDER WITH THE WRITTEN  
22 CONSENT OF THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED  
23 REPRESENTATIVE MAY APPEAL THE DENIAL OF A GRIEVANCE FOLLOWING  
24 COMPLETION OF THE INTERNAL GRIEVANCE PROCESS. THE EXTERNAL  
25 GRIEVANCE PROCESS SHALL BE CONDUCTED BY AN [INDEPENDENT <--  
26 UTILIZATION REVIEW ENTITY] REVIEW ORGANIZATION NOT DIRECTLY <--  
27 AFFILIATED WITH THE MA OR CHIP MANAGED CARE PLAN.

28 (B) TO CONDUCT EXTERNAL GRIEVANCES FILED UNDER THIS SECTION:

29 (1) THE DEPARTMENT SHALL RANDOMLY ASSIGN [A UTILIZATION  
30 REVIEW ENTITY] AN IRQ ON A ROTATIONAL BASIS FROM THE LIST

1 MAINTAINED UNDER SUBSECTION (D) AND NOTIFY THE ASSIGNED  
2 [UTILIZATION REVIEW ENTITY] IRO AND THE MA OR CHIP MANAGED CARE  
3 PLAN WITHIN TWO (2) BUSINESS DAYS OF RECEIVING THE REQUEST. IF  
4 THE DEPARTMENT FAILS TO SELECT [A UTILIZATION REVIEW ENTITY] AN  
5 IRO UNDER THIS SUBSECTION, THE MA OR CHIP MANAGED CARE PLAN  
6 SHALL DESIGNATE AND NOTIFY A CERTIFIED [UTILIZATION REVIEW  
7 ENTITY] IRO TO CONDUCT THE EXTERNAL GRIEVANCE.

8 (2) [THE MA OR CHIP MANAGED CARE PLAN SHALL NOTIFY THE <--  
9 ENROLLEE, THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OR HEALTH <--  
10 CARE PROVIDER OF THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE  
11 [UTILIZATION REVIEW ENTITY] IRO ASSIGNED UNDER THIS SUBSECTION <--  
12 WITHIN TWO (2) BUSINESS DAYS.] WITHIN THE SAME TWO (2) BUSINESS <--  
13 DAY TIME FRAME SET FORTH IN PARAGRAPH (1), THE DEPARTMENT SHALL  
14 NOTIFY THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE  
15 OF THE NAME, ADDRESS, E-MAIL ADDRESS, FAX NUMBER AND TELEPHONE  
16 NUMBER OF THE IRO ASSIGNED UNDER THIS SUBSECTION. THE NOTICE  
17 SHALL INFORM THE ENROLLEE AND THE ENROLLEE'S AUTHORIZED  
18 REPRESENTATIVE OF THE RIGHT TO SUBMIT ADDITIONAL WRITTEN  
19 INFORMATION TO THE IRO WITHIN TWENTY (20) DAYS OF THE DATE THE  
20 IRO ASSIGNMENT NOTICE WAS MAILED AND SHALL INCLUDE INSTRUCTIONS  
21 FOR SUBMITTING ADDITIONAL INFORMATION TO THE IRO BY MAIL,  
22 FACSIMILE AND ELECTRONICALLY.

23 (C) THE EXTERNAL GRIEVANCE PROCESS SHALL MEET ALL OF THE  
24 FOLLOWING REQUIREMENTS:

25 (1) ANY EXTERNAL GRIEVANCE SHALL BE FILED WITH THE MA OR  
26 CHIP MANAGED CARE PLAN WITHIN FIFTEEN (15) DAYS OF RECEIPT OF A  
27 NOTICE OF DENIAL RESULTING FROM THE INTERNAL GRIEVANCE PROCESS.  
28 THE FILING OF THE EXTERNAL GRIEVANCE SHALL INCLUDE ANY MATERIAL  
29 JUSTIFICATION AND ALL REASONABLY NECESSARY SUPPORTING  
30 INFORMATION. WITHIN FIVE (5) BUSINESS DAYS OF THE FILING OF AN



1 EXTERNAL GRIEVANCE, THE MA OR CHIP MANAGED CARE PLAN SHALL  
2 NOTIFY THE ENROLLEE, THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OR  
3 THE HEALTH CARE PROVIDER [~~THE [UTILIZATION REVIEW ENTITY] IRO~~ <--  
4 THAT CONDUCTED THE INTERNAL GRIEVANCE] AND THE DEPARTMENT THAT <--  
5 AN EXTERNAL GRIEVANCE HAS BEEN FILED.

6 (2) THE [UTILIZATION REVIEW ENTITY] ~~IRO~~ MA OR CHIP MANAGED <--  
7 CARE PLAN THAT CONDUCTED THE INTERNAL GRIEVANCE SHALL FORWARD  
8 COPIES OF ALL WRITTEN DOCUMENTATION REGARDING THE DENIAL,  
9 INCLUDING THE DECISION, ALL REASONABLY NECESSARY SUPPORTING  
10 INFORMATION, A SUMMARY OF APPLICABLE ISSUES AND THE BASIS AND  
11 CLINICAL RATIONALE FOR THE DECISION, TO THE [UTILIZATION REVIEW <--  
12 ENTITY] IRO CONDUCTING THE EXTERNAL GRIEVANCE WITHIN FIFTEEN <--  
13 (15) DAYS OF RECEIPT OF NOTICE THAT THE EXTERNAL GRIEVANCE WAS  
14 FILED. ANY ADDITIONAL WRITTEN INFORMATION MAY BE SUBMITTED BY  
15 THE ENROLLEE, THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OR THE  
16 HEALTH CARE PROVIDER WITHIN [FIFTEEN (15) DAYS OF RECEIPT OF  
17 NOTICE THAT THE EXTERNAL GRIEVANCE WAS FILED] TWENTY (20) DAYS  
18 OF THE DATE THE NOTICE OF THE IRO ASSIGNMENT WAS MAILED TO THE <--  
19 ENROLLEE OR, ENROLLEE'S REPRESENTATIVE OR HEALTH CARE PROVIDER. <--

20 (3) THE [UTILIZATION REVIEW ENTITY] IRO CONDUCTING THE  
21 EXTERNAL GRIEVANCE SHALL REVIEW ALL INFORMATION CONSIDERED IN  
22 REACHING ANY PRIOR DECISIONS TO DENY PAYMENT FOR THE HEALTH CARE  
23 SERVICE AND ANY OTHER WRITTEN SUBMISSION BY THE ENROLLEE, THE  
24 ENROLLEE'S AUTHORIZED REPRESENTATIVE OR THE HEALTH CARE  
25 PROVIDER.

26 (4) AN EXTERNAL GRIEVANCE DECISION SHALL BE MADE BY:

27 (I) ONE OR MORE LICENSED PHYSICIANS [~~OR~~ APPROVED] <--  
28 LICENSED PSYCHOLOGISTS OR APPROVED LICENSED DENTISTS IN ACTIVE <--  
29 CLINICAL PRACTICE OR IN THE SAME OR SIMILAR SPECIALTY THAT  
30 TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE HEALTH CARE

1 SERVICE BEING REVIEWED; OR

2 (II) ONE OR MORE PHYSICIANS CURRENTLY CERTIFIED BY A BOARD  
3 APPROVED BY THE AMERICAN BOARD OF MEDICAL SPECIALISTS OR THE  
4 AMERICAN BOARD OF OSTEOPATHIC SPECIALTIES IN THE SAME OR SIMILAR  
5 SPECIALTY THAT TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE  
6 HEALTH CARE SERVICE BEING REVIEWED.

7 (5) WITHIN SIXTY (60) DAYS OF THE FILING OF THE EXTERNAL  
8 GRIEVANCE, THE [UTILIZATION REVIEW ENTITY] IRO CONDUCTING THE  
9 EXTERNAL GRIEVANCE SHALL ISSUE A WRITTEN DECISION TO THE MA OR  
10 CHIP MANAGED CARE PLAN, THE ENROLLEE, THE ENROLLEE'S AUTHORIZED  
11 REPRESENTATIVE IF THE ENROLLEE'S AUTHORIZED REPRESENTATIVE  
12 REQUESTED THE EXTERNAL REVIEW, AND THE HEALTH CARE PROVIDER,  
13 INCLUDING THE BASIS AND CLINICAL RATIONALE FOR THE DECISION. THE  
14 STANDARD OF REVIEW SHALL BE WHETHER THE HEALTH CARE SERVICE  
15 DENIED BY THE INTERNAL GRIEVANCE PROCESS WAS MEDICALLY NECESSARY  
16 AND APPROPRIATE UNDER THE TERMS OF THE ~~MA OR CHIP MANAGED CARE~~ <--  
17 ~~PLAN~~ AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES. THE <--  
18 EXTERNAL GRIEVANCE DECISION SHALL BE SUBJECT TO APPEAL TO A  
19 COURT OF COMPETENT JURISDICTION WITHIN SIXTY (60) DAYS OF  
20 RECEIPT OF NOTICE OF THE EXTERNAL GRIEVANCE DECISION. THERE  
21 SHALL BE A REBUTTABLE PRESUMPTION IN FAVOR OF THE DECISION OF  
22 THE [UTILIZATION REVIEW ENTITY] IRO CONDUCTING THE EXTERNAL  
23 GRIEVANCE.

24 (6) THE MA OR CHIP MANAGED CARE PLAN SHALL AUTHORIZE ANY  
25 HEALTH CARE SERVICE OR PAY A CLAIM DETERMINED TO BE MEDICALLY  
26 NECESSARY AND APPROPRIATE UNDER PARAGRAPH (5) PURSUANT TO  
27 SECTION 2166 WHETHER OR NOT AN APPEAL TO A COURT OF COMPETENT  
28 JURISDICTION HAS BEEN FILED.

29 (7) ALL FEES AND COSTS RELATED TO AN EXTERNAL GRIEVANCE  
30 SHALL BE PAID BY THE NONPREVAILING PARTY IF THE EXTERNAL

1 GRIEVANCE WAS FILED BY THE HEALTH CARE PROVIDER AND THE HEALTH <--  
2 CARE PROVIDER WAS NOT THE ENROLLEE'S AUTHORIZED REPRESENTATIVE.  
3 THE HEALTH CARE PROVIDER AND THE [UTILIZATION REVIEW ENTITY] ~~IRO~~ <--  
4 OR] MA OR CHIP MANAGED CARE PLAN SHALL EACH PLACE IN ESCROW AN <--  
5 AMOUNT EQUAL TO ONE-HALF OF THE ESTIMATED FEEES AND COSTS OF THE <--  
6 EXTERNAL GRIEVANCE PROCESS. IF THE EXTERNAL GRIEVANCE WAS FILED  
7 BY THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE, ALL  
8 FEES AND COSTS RELATED THERETO SHALL BE PAID BY THE MA OR CHIP  
9 MANAGED CARE PLAN. FOR PURPOSES OF THIS PARAGRAPH, FEES AND  
10 COSTS SHALL NOT INCLUDE ATTORNEY FEES.

11 (D) THE DEPARTMENT SHALL COMPILE AND MAINTAIN A LIST OF  
12 [CERTIFIED UTILIZATION REVIEW ENTITIES] IROS THAT MEET THE  
13 REQUIREMENTS OF THIS ARTICLE. THE DEPARTMENT MAY REMOVE [A  
14 UTILIZATION REVIEW ENTITY] AN IRO FROM THE LIST IF SUCH AN  
15 ENTITY IS INCAPABLE OF PERFORMING ITS RESPONSIBILITIES IN A  
16 REASONABLE MANNER, CHARGES EXCESSIVE FEES OR VIOLATES THIS  
17 ARTICLE.

18 (E) A FEE MAY BE IMPOSED BY [A] AN MA OR CHIP MANAGED CARE  
19 PLAN FOR FILING AN EXTERNAL GRIEVANCE PURSUANT TO THIS ARTICLE  
20 WHICH SHALL NOT EXCEED TWENTY-FIVE (\$25) DOLLARS.

21 (F) WRITTEN CONTRACTS BETWEEN MA OR CHIP MANAGED CARE PLANS  
22 AND HEALTH CARE PROVIDERS MAY PROVIDE AN ALTERNATIVE DISPUTE  
23 RESOLUTION SYSTEM TO THE EXTERNAL GRIEVANCE PROCESS SET FORTH IN  
24 THIS ARTICLE IF THE DEPARTMENT APPROVES THE CONTRACT. THE  
25 ALTERNATIVE DISPUTE RESOLUTION SYSTEM SHALL BE IMPARTIAL,  
26 INCLUDE SPECIFIC TIME LIMITATIONS TO INITIATE APPEALS, RECEIVE  
27 WRITTEN INFORMATION, CONDUCT HEARINGS AND RENDER DECISIONS AND  
28 OTHERWISE SATISFY THE REQUIREMENTS OF THIS SECTION. A WRITTEN  
29 DECISION PURSUANT TO AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM  
30 SHALL BE FINAL AND BINDING ON ALL PARTIES. AN ALTERNATIVE

1 DISPUTE RESOLUTION SYSTEM SHALL NOT BE UTILIZED FOR ANY EXTERNAL  
2 GRIEVANCE FILED BY AN ENROLLEE OR ENROLLEE'S AUTHORIZED  
3 REPRESENTATIVE.

4 SECTION 2163. RECORDS.--RECORDS REGARDING GRIEVANCES FILED  
5 UNDER THIS SUBDIVISION THAT RESULT IN DECISIONS ADVERSE TO  
6 ENROLLEES SHALL BE MAINTAINED BY THE MA OR CHIP MANAGED CARE  
7 PLAN FOR NOT LESS THAN THREE (3) YEARS. THESE RECORDS SHALL BE  
8 PROVIDED TO THE DEPARTMENT, IF REQUESTED, IN ACCORDANCE WITH  
9 SECTION 2131(C) (2) (II).

10 SECTION 7. ARTICLE XXI OF THE ACT IS AMENDED BY ADDING A  
11 SUBDIVISION TO READ:

12 (I.1) ADVERSE BENEFIT DETERMINATIONS.

13 SECTION 2164. INTERNAL ADVERSE BENEFIT DETERMINATION PROCESS  
14 FOR INSURER.

15 (A) DETERMINATION PROCESS.--AN INSURER SHALL ESTABLISH AND  
16 MAINTAIN AN INTERNAL ADVERSE BENEFIT DETERMINATION PROCESS THAT  
17 COMPLIES WITH SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT (58  
18 STAT. 682, 42 U.S.C. § 300GG-19) AND REGULATIONS PROMULGATED  
19 UNDER THE PUBLIC HEALTH SERVICE ACT.

20 (B) NOTICE.--FOLLOWING AN ADVERSE BENEFIT DETERMINATION AND  
21 PRIOR TO ANY APPEAL OF AN ADVERSE BENEFIT DETERMINATION UNDER  
22 SUBSECTION (A), AN INSURER SHALL PROVIDE A COVERED PERSON OR  
23 COVERED PERSON'S AUTHORIZED REPRESENTATIVE NOTICE OF THE COVERED  
24 PERSON'S RIGHT TO APPEAL AN ADVERSE BENEFIT DETERMINATION WHICH  
25 SHALL BE IN A FORM APPROVED BY THE DEPARTMENT.

26 SECTION 2164.1. EXTERNAL REVIEW APPLICABILITY AND SCOPE.

27 (A) APPLICABILITY.--THE EXTERNAL REVIEW PROVISIONS OF THIS  
28 SUBDIVISION SHALL APPLY TO:

29 (1) AN ADVERSE BENEFIT DETERMINATION RENDERED BY AN  
30 INSURER THAT ARE BASED ON ANY OF THE FOLLOWING:

- 1           (I) MEDICAL NECESSITY.
- 2           (II) APPROPRIATENESS OF SERVICE.
- 3           (III) HEALTH CARE SETTING.
- 4           (IV) LEVEL OF CARE.
- 5           (V) EFFECTIVENESS OF A COVERED BENEFIT.

6           (2) ~~(RESERVED)~~. DISPUTES REGARDING AN INSURER'S           <--  
7           COMPLIANCE WITH THE SURPRISE BILLING AND COST-SHARING  
8           PROTECTIONS UNDER SECTIONS 2799A-1 AND 2799A-2 OF THE PUBLIC  
9           HEALTH SERVICE ACT (58 STAT. 682, 42 U.S.C. § 300GG-19) AND  
10           REGULATIONS PROMULGATED THEREUNDER.

11           (B) NONAPPLICABILITY.--THE EXTERNAL REVIEW PROVISIONS OF  
12           THIS SUBDIVISION DO NOT APPLY TO:

13           (1) COMPLAINTS, WHICH MAY BE APPEALED UNDER SECTION  
14           2142.

15           (2) GRIEVANCES, WHICH MAY BE REVIEWED UNDER SECTION  
16           2162.

17           (3) ~~ADMINISTRATIVE ADVERSE BENEFIT DETERMINATIONS~~           <--  
18           DENIALS, WHICH MAY BE APPEALED UNDER SECTION 2142.           <--

19           (C) NO MINIMUM THRESHOLD.--THE EXTERNAL REVIEW PROCESS IS  
20           AVAILABLE TO A COVERED PERSON OR COVERED PERSON'S AUTHORIZED  
21           REPRESENTATIVE WITH RESPECT TO HEALTH CARE SERVICES OF ANY  
22           MONETARY VALUE. THERE IS NO MINIMUM FINANCIAL THRESHOLD FOR  
23           FILING A REQUEST FOR EXTERNAL REVIEW.

24           SECTION 2164.2. NOTICE OF RIGHT TO EXTERNAL REVIEW.

25           (A) TIMING OF NOTICE.--AN INSURER SHALL NOTIFY A COVERED  
26           PERSON IN WRITING OF THE COVERED PERSON'S RIGHT TO REQUEST AN  
27           EXTERNAL REVIEW UNDER SECTION 2164.5, 2164.6 OR 2164.7 AT THE  
28           SAME TIME THE INSURER SENDS WRITTEN NOTICE IN A FORM APPROVED BY  
29           THE DEPARTMENT OF EITHER OF THE FOLLOWING:

30           (1) AN ADVERSE BENEFIT DETERMINATION UPON COMPLETION OF

1 THE INSURER'S UTILIZATION REVIEW PROCESS.

2 (2) A FINAL ADVERSE BENEFIT DETERMINATION.

3 (B) CONTENT OF NOTICE.--THE NOTICE SHALL INCLUDE:

4 (1) THE FOLLOWING, OR SUBSTANTIALLY EQUIVALENT,  
5 LANGUAGE:

6 WE HAVE DENIED YOUR REQUEST FOR THE PROVISION OF OR  
7 PAYMENT FOR A HEALTH CARE SERVICE OR COURSE OF  
8 TREATMENT. YOU MAY HAVE THE RIGHT TO HAVE OUR  
9 DECISION REVIEWED BY HEALTH CARE PROVIDERS WHO HAVE  
10 NO ASSOCIATION WITH US IF OUR DECISION INVOLVED  
11 MAKING A JUDGMENT AS TO THE MEDICAL NECESSITY,  
12 APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE  
13 OR EFFECTIVENESS OF THE HEALTH CARE SERVICE OR  
14 TREATMENT YOU REQUESTED. YOU ALSO HAVE THE RIGHT TO A  
15 REVIEW OF WHETHER WE HAVE COMPLIED WITH THE SURPRISE  
16 BILLING AND COST-SHARING PROTECTIONS UNDER THE NO  
17 SURPRISES ACT. YOU MAY SUBMIT A REQUEST FOR EXTERNAL  
18 REVIEW TO THE PENNSYLVANIA INSURANCE DEPARTMENT.

19 (2) FOR A NOTICE RELATED TO AN ADVERSE BENEFIT  
20 DETERMINATION, A STATEMENT INFORMING THE COVERED PERSON THAT:

21 (I) IF THE COVERED PERSON HAS A MEDICAL CONDITION  
22 FOR WHICH THE TIME FRAME FOR COMPLETION OF AN EXPEDITED  
23 REVIEW OF AN ADVERSE BENEFIT DETERMINATION UNDER SECTION  
24 2164 WOULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE  
25 COVERED PERSON OR WOULD JEOPARDIZE THE COVERED PERSON'S  
26 ABILITY TO REGAIN MAXIMUM FUNCTION, THE COVERED PERSON,  
27 OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE, MAY  
28 FILE A REQUEST FOR AN EXPEDITED EXTERNAL REVIEW AT THE  
29 SAME TIME AS A REQUEST FOR AN EXPEDITED REVIEW OF AN  
30 ADVERSE BENEFIT DETERMINATION UNDER SECTION 2164. THE IRO

1 ASSIGNED TO CONDUCT THE EXPEDITED EXTERNAL REVIEW SHALL  
2 DETERMINE WHETHER THE COVERED PERSON IS REQUIRED TO  
3 COMPLETE THE EXPEDITED REVIEW OF THE ADVERSE BENEFIT  
4 DETERMINATION PRIOR TO CONDUCTING THE EXPEDITED EXTERNAL  
5 REVIEW. THE REQUEST MAY BE FILED UNDER SECTION 2164.6 OR  
6 2164.7 IF:

7 (A) THE ADVERSE BENEFIT DETERMINATION INVOLVES A  
8 DENIAL OF COVERAGE BASED ON A DETERMINATION THAT THE  
9 RECOMMENDED OR REQUESTED HEALTH CARE SERVICES ARE  
10 EXPERIMENTAL OR INVESTIGATIONAL.

11 (B) THE COVERED PERSON'S TREATING HEALTH CARE  
12 PROVIDER CERTIFIES IN WRITING THAT THE RECOMMENDED OR  
13 REQUESTED HEALTH CARE SERVICES THAT ARE THE SUBJECT  
14 OF THE ADVERSE BENEFIT DETERMINATION WOULD BE  
15 SIGNIFICANTLY LESS EFFECTIVE IF NOT PROMPTLY  
16 INITIATED.

17 (II) THE COVERED PERSON OR THE COVERED PERSON'S  
18 AUTHORIZED REPRESENTATIVE MAY FILE AN APPEAL UNDER THE  
19 INSURER'S INTERNAL APPEAL PROCESS UNDER SECTION 2164, BUT  
20 SHALL BE CONSIDERED TO HAVE EXHAUSTED THE INSURER'S  
21 INTERNAL APPEAL PROCESS FOR PURPOSES OF SECTION 2164.4  
22 AND MAY IMMEDIATELY FILE A REQUEST FOR EXTERNAL REVIEW  
23 UNDER SECTION 2164.3 IF:

24 (A) THE INSURER HAS NOT ISSUED A WRITTEN  
25 DECISION TO THE COVERED PERSON OR THE COVERED  
26 PERSON'S AUTHORIZED REPRESENTATIVE WITHIN 30 DAYS  
27 FOLLOWING THE DATE THE COVERED PERSON OR THE COVERED  
28 PERSON'S AUTHORIZED REPRESENTATIVE FILES THE APPEAL  
29 WITH THE INSURER.

30 (B) THE COVERED PERSON OR THE COVERED PERSON'S

1 AUTHORIZED REPRESENTATIVE HAS NOT REQUESTED OR AGREED  
2 TO A DELAY.

3 (C) THE INSURER WAIVES ITS INTERNAL CLAIM AND  
4 APPEAL PROCESS AND THE REQUIREMENT FOR A COVERED  
5 PERSON OR COVERED PERSON'S AUTHORIZED REPRESENTATIVE  
6 TO EXHAUST THE PROCESS BEFORE FILING A REQUEST FOR AN  
7 EXTERNAL REVIEW OR AN EXPEDITED EXTERNAL REVIEW.

8 (D) THE INSURER HAS FAILED TO COMPLY WITH THE  
9 REQUIREMENTS OF THE INTERNAL CLAIM AND APPEAL PROCESS  
10 UNLESS THE FAILURE OR FAILURES ARE BASED ON DE  
11 MINIMIS VIOLATIONS THAT DO NOT CAUSE, AND ARE NOT  
12 LIKELY TO CAUSE, PREJUDICE OR HARM TO THE COVERED  
13 PERSON OR COVERED PERSON'S AUTHORIZED REPRESENTATIVE.

14 (3) FOR A NOTICE RELATED TO A FINAL ADVERSE BENEFIT  
15 DETERMINATION, A STATEMENT INFORMING THE COVERED PERSON THAT:

16 (I) IF THE COVERED PERSON HAS A MEDICAL CONDITION  
17 FOR WHICH THE TIME FRAME FOR COMPLETION OF A STANDARD  
18 EXTERNAL REVIEW UNDER SECTION 2164.5 WOULD SERIOUSLY  
19 JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR  
20 WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN  
21 MAXIMUM FUNCTION, THE COVERED PERSON OR COVERED PERSON'S  
22 AUTHORIZED REPRESENTATIVE MAY FILE A REQUEST FOR AN  
23 EXPEDITED EXTERNAL REVIEW UNDER SECTION 2164.6.

24 (II) IF THE FINAL ADVERSE BENEFIT DETERMINATION  
25 CONCERNS:

26 (A) AN ADMISSION, AVAILABILITY OF CARE,  
27 CONTINUED STAY OR HEALTH CARE SERVICE FOR WHICH THE  
28 COVERED PERSON RECEIVED EMERGENCY SERVICES, BUT HAS  
29 NOT BEEN DISCHARGED FROM A FACILITY, THE COVERED  
30 PERSON OR THE COVERED PERSON'S AUTHORIZED



1 REPRESENTATIVE MAY REQUEST AN EXPEDITED EXTERNAL  
2 REVIEW UNDER SECTION 2164.6.

3 (B) A DENIAL OF COVERAGE BASED ON A  
4 DETERMINATION THAT THE RECOMMENDED OR REQUESTED  
5 HEALTH CARE SERVICE IS EXPERIMENTAL OR  
6 INVESTIGATIONAL, THE COVERED PERSON OR COVERED  
7 PERSON'S AUTHORIZED REPRESENTATIVE MAY FILE A REQUEST  
8 FOR A STANDARD EXTERNAL REVIEW TO BE CONDUCTED UNDER  
9 SECTION 2164.7.

10 (C) A WRITTEN CERTIFICATION BY THE TREATING  
11 HEALTH CARE PROVIDER THAT THE RECOMMENDED OR  
12 REQUESTED HEALTH CARE SERVICE THAT IS THE SUBJECT OF  
13 THE REQUEST WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF  
14 NOT PROMPTLY INITIATED, THE COVERED PERSON OR THE  
15 COVERED PERSON'S AUTHORIZED REPRESENTATIVE MAY  
16 REQUEST AN EXPEDITED EXTERNAL REVIEW TO BE CONDUCTED  
17 UNDER SECTION ~~2164.7~~ 2164.6. <--

18 (4) A COPY OF THE DESCRIPTION OF BOTH THE STANDARD AND  
19 EXPEDITED EXTERNAL REVIEW PROCEDURES REQUIRED BY SECTION  
20 ~~2136.1~~ 2136(C) THAT HIGHLIGHTS THE PROVISIONS IN THE EXTERNAL <--  
21 REVIEW PROCEDURES REGARDING THE OPPORTUNITY TO SUBMIT  
22 ADDITIONAL INFORMATION AND ANY FORMS USED TO PROCESS AN  
23 EXTERNAL REVIEW.

24 (5) AN AUTHORIZATION FORM, OR OTHER DOCUMENT APPROVED BY  
25 THE DEPARTMENT THAT COMPLIES WITH THE REQUIREMENTS OF 45 CFR  
26 164.508 (RELATING TO USES AND DISCLOSURES FOR WHICH AN  
27 AUTHORIZATION IS REQUIRED), BY WHICH THE COVERED PERSON, FOR  
28 PURPOSES OF CONDUCTING AN EXTERNAL REVIEW UNDER THIS  
29 SUBDIVISION, AUTHORIZES THE INSURER AND THE COVERED PERSON'S  
30 TREATING HEALTH CARE PROVIDER TO DISCLOSE PROTECTED HEALTH

1 INFORMATION, INCLUDING MEDICAL RECORDS, CONCERNING THE  
2 COVERED PERSON, THAT ARE PERTINENT TO THE EXTERNAL REVIEW.  
3 SECTION 2164.3. REQUEST FOR EXTERNAL REVIEW.

4 (A) FORM OF REQUEST.--

5 (1) EXCEPT FOR A REQUEST FOR AN EXPEDITED EXTERNAL  
6 REVIEW UNDER SECTION 2164.6, A REQUEST FOR EXTERNAL REVIEW  
7 SHALL BE MADE IN WRITING TO THE DEPARTMENT.

8 (2) THE DEPARTMENT MAY PRESCRIBE BY REGULATION THE FORM  
9 AND CONTENT OF AN EXTERNAL REVIEW REQUEST REQUIRED TO BE  
10 SUBMITTED UNDER THIS SECTION.

11 (B) PERMITTED REQUESTS.--A COVERED PERSON OR THE COVERED  
12 PERSON'S AUTHORIZED REPRESENTATIVE MAY MAKE A REQUEST FOR AN  
13 EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR FINAL  
14 ADVERSE BENEFIT DETERMINATION.

15 SECTION 2164.4. EXHAUSTION OF INTERNAL APPEAL PROCESS.

16 (A) REQUIREMENT TO EXHAUST INTERNAL APPEAL PROCESS.--

17 (1) EXCEPT AS PROVIDED IN SUBSECTION (B), A REQUEST FOR  
18 EXTERNAL REVIEW UNDER SECTION 2164.5, 2164.6 OR 2164.7 OR A  
19 REQUEST FOR RETROSPECTIVE UTILIZATION REVIEW UNDER SECTION <--  
20 2164 MAY NOT BE MADE UNTIL THE COVERED PERSON HAS EXHAUSTED  
21 THE INSURER'S INTERNAL APPEAL PROCESS UNDER SECTION 2164.

22 (2) A COVERED PERSON IS CONSIDERED TO HAVE EXHAUSTED THE  
23 INSURER'S INTERNAL APPEAL PROCESS FOR PURPOSES OF THIS  
24 SECTION IF THE COVERED PERSON OR THE COVERED PERSON'S  
25 AUTHORIZED REPRESENTATIVE:

26 (I) HAS FILED AN APPEAL INVOLVING AN ADVERSE BENEFIT  
27 DETERMINATION UNDER SECTION 2164.

28 (II) EXCEPT TO THE EXTENT THE COVERED PERSON OR THE  
29 COVERED PERSON'S AUTHORIZED REPRESENTATIVE REQUESTED OR  
30 AGREED TO A DELAY, HAS NOT RECEIVED A WRITTEN DECISION ON

1 THE APPEAL FROM THE INSURER WITHIN 30 DAYS FOLLOWING THE  
2 DATE THE COVERED PERSON OR THE COVERED PERSON'S  
3 AUTHORIZED REPRESENTATIVE FILED THE APPEAL WITH THE  
4 INSURER.

5 (III) THE INSURER WAIVES ITS INTERNAL CLAIM AND  
6 APPEAL PROCESS AND THE REQUIREMENT FOR A COVERED PERSON  
7 OR COVERED PERSON'S AUTHORIZED REPRESENTATIVE TO EXHAUST  
8 THE PROCESS BEFORE FILING A REQUEST FOR AN EXTERNAL  
9 REVIEW OR AN EXPEDITED EXTERNAL REVIEW.

10 (IV) THE INSURER HAS FAILED TO COMPLY WITH THE  
11 REQUIREMENTS OF THE INTERNAL CLAIM AND APPEAL PROCESS  
12 UNLESS THE FAILURE OR FAILURES ARE BASED ON DE MINIMIS  
13 VIOLATIONS THAT DO NOT CAUSE, AND ARE NOT LIKELY TO  
14 CAUSE, PREJUDICE OR HARM TO THE COVERED PERSON OR COVERED  
15 PERSON'S AUTHORIZED REPRESENTATIVE.

16 (B) PROCEDURE FOR REQUESTING EXPEDITED EXTERNAL REVIEW.--

17 (1) AT THE SAME TIME A COVERED PERSON OR THE COVERED  
18 PERSON'S AUTHORIZED REPRESENTATIVE FILES A REQUEST FOR  
19 EXPEDITED INTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION  
20 UNDER SECTION 2164, THE COVERED PERSON OR THE COVERED  
21 PERSON'S AUTHORIZED REPRESENTATIVE MAY FILE A REQUEST FOR AN  
22 EXPEDITED EXTERNAL REVIEW OF THE ADVERSE BENEFIT  
23 DETERMINATION:

24 (I) UNDER SECTION 2164.6, IF THE COVERED PERSON HAS  
25 A MEDICAL CONDITION FOR WHICH THE TIME FRAME FOR  
26 COMPLETION OF AN EXPEDITED INTERNAL REVIEW OF THE ADVERSE  
27 BENEFIT DETERMINATION UNDER SECTION 2164 WOULD SERIOUSLY  
28 JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR  
29 WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN  
30 MAXIMUM FUNCTION.

1           (II) UNDER SECTION 2164.7, IF THE ADVERSE BENEFIT  
2           DETERMINATION INVOLVES A DENIAL OF COVERAGE BASED ON A  
3           DETERMINATION THAT THE RECOMMENDED OR REQUESTED HEALTH  
4           CARE SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL, AND THE  
5           COVERED PERSON'S TREATING HEALTH CARE PROVIDER CERTIFIES  
6           IN WRITING THAT THE RECOMMENDED OR REQUESTED HEALTH CARE  
7           SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT  
8           DETERMINATION WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF  
9           NOT PROMPTLY INITIATED.

10          (2) UPON RECEIPT OF A REQUEST FOR AN EXPEDITED EXTERNAL  
11          REVIEW UNDER PARAGRAPH (1), THE IRO CONDUCTING THE EXTERNAL  
12          REVIEW UNDER SECTION 2164.6 OR SECTION 2164.7 SHALL DETERMINE  
13          WHETHER THE COVERED PERSON IS REQUIRED TO COMPLETE THE  
14          EXPEDITED INTERNAL REVIEW PROCESS UNDER SECTION 2164 BEFORE  
15          THE IRO CONDUCTS THE EXPEDITED EXTERNAL REVIEW.

16          (C) DENIAL OF REQUEST FOR EXPEDITED EXTERNAL REVIEW.--IF THE  
17          IRO DETERMINES THAT THE COVERED PERSON IS REQUIRED TO FIRST  
18          COMPLETE THE INTERNAL EXPEDITED APPEAL PROCESS UNDER SECTION  
19          2164, THE IRO SHALL WITHIN 24 HOURS NOTIFY THE COVERED PERSON  
20          AND, IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
21          REPRESENTATIVE, THAT THE IRO MAY NOT PROCEED WITH THE EXPEDITED  
22          EXTERNAL REVIEW UNDER SECTION 2164.6 UNTIL THE INSURER HAS  
23          COMPLETED THE EXPEDITED REVIEW PROCESS AND THE COVERED PERSON'S  
24          ADVERSE BENEFIT DETERMINATION APPEAL REMAINS UNRESOLVED.

25          (D) WAIVER OF EXHAUSTION REQUIREMENT.--A REQUEST FOR  
26          EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION MAY BE MADE  
27          BEFORE THE COVERED PERSON HAS EXHAUSTED THE INSURER'S INTERNAL  
28          APPEAL PROCEDURES UNDER SECTION 2164, IF THE INSURER AGREES TO  
29          WAIVE THE EXHAUSTION REQUIREMENT. AT THAT TIME, THE COVERED  
30          PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE MAY

1 FILE A REQUEST IN WRITING FOR STANDARD EXTERNAL REVIEW AS  
2 PROVIDED IN SECTION 2164.5 OR SECTION 2164.7.  
3 SECTION 2164.5. STANDARD EXTERNAL REVIEW.

4 (A) REQUEST FOR REVIEW.--

5 (1) A COVERED PERSON, OR THE COVERED PERSON'S AUTHORIZED  
6 REPRESENTATIVE, MAY FILE A REQUEST FOR EXTERNAL REVIEW WITH  
7 THE DEPARTMENT WITHIN FOUR MONTHS AFTER THE DATE OF RECEIPT  
8 OF A NOTICE OF AN ADVERSE BENEFIT DETERMINATION OR FINAL  
9 ADVERSE BENEFIT DETERMINATION UNDER SECTION 2164.2.

10 (2) THE DEPARTMENT SHALL SEND A COPY OF THE REQUEST TO  
11 THE INSURER WITHIN ONE BUSINESS DAY OF THE DATE OF RECEIPT OF  
12 A REQUEST FOR EXTERNAL REVIEW UNDER PARAGRAPH (1).

13 (B) PRELIMINARY REVIEW OF REQUEST.--WITHIN FIVE BUSINESS  
14 DAYS OF THE DATE OF RECEIPT OF THE COPY OF THE EXTERNAL REVIEW  
15 REQUEST RECEIVED UNDER SUBSECTION (A) (2), THE INSURER SHALL  
16 COMPLETE A PRELIMINARY REVIEW OF THE REQUEST TO DETERMINE  
17 WHETHER:

18 (1) THE INDIVIDUAL IS OR WAS A COVERED PERSON UNDER THE  
19 HEALTH INSURANCE POLICY AT THE TIME THE HEALTH CARE SERVICE  
20 WAS REQUESTED OR, IN THE CASE OF A RETROSPECTIVE UTILIZATION <--  
21 REVIEW, WAS A COVERED PERSON UNDER THE HEALTH INSURANCE  
22 POLICY AT THE TIME THE HEALTH CARE SERVICE WAS PROVIDED.

23 (2) THE HEALTH CARE SERVICE THAT IS THE SUBJECT OF THE  
24 ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT  
25 DETERMINATION IS A COVERED ~~SERVICE~~ BENEFIT UNDER THE COVERED <--  
26 PERSON'S HEALTH INSURANCE POLICY, EXCEPT FOR A DETERMINATION  
27 BY THE INSURER THAT THE HEALTH CARE SERVICE IS NOT COVERED  
28 BECAUSE IT DOES NOT MEET THE INSURER'S REQUIREMENTS FOR  
29 MEDICAL NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING,  
30 LEVEL OF CARE OR EFFECTIVENESS.

1           (3) THE COVERED PERSON HAS EXHAUSTED THE INSURER'S  
2 INTERNAL APPEAL PROCESS UNDER SECTION 2164, UNLESS THE  
3 COVERED PERSON IS NOT REQUIRED TO EXHAUST THE INSURER'S  
4 INTERNAL APPEAL PROCESS UNDER SECTION 2164.4.

5           (4) THE COVERED PERSON HAS NOT PROVIDED ALL THE  
6 INFORMATION AND FORMS REQUIRED TO PROCESS AN EXTERNAL REVIEW,  
7 INCLUDING THE RELEASE FORM PROVIDED UNDER SECTION 2164.2(B).  
8 (C) NOTICE OF INITIAL DETERMINATION.--

9           (1) WITHIN ONE BUSINESS DAY OF COMPLETION OF THE  
10 PRELIMINARY REVIEW, THE INSURER SHALL NOTIFY THE DEPARTMENT  
11 AND THE COVERED PERSON AND, IF APPLICABLE, THE COVERED  
12 PERSON'S AUTHORIZED REPRESENTATIVE, IN WRITING WHETHER THE  
13 REQUEST IS COMPLETE AND ELIGIBLE FOR EXTERNAL REVIEW. THE  
14 FOLLOWING APPLY:

15           (I) IF THE REQUEST IS NOT COMPLETE, THE INSURER  
16 SHALL INFORM THE COVERED PERSON AND, IF APPLICABLE, THE  
17 COVERED PERSON'S AUTHORIZED REPRESENTATIVE, AND THE  
18 DEPARTMENT IN WRITING AND INCLUDE IN THE NOTICE WHAT  
19 INFORMATION OR MATERIALS ARE NEEDED TO MAKE THE REQUEST  
20 COMPLETE.

21           (II) IF THE REQUEST IS NOT ELIGIBLE FOR EXTERNAL  
22 REVIEW, THE INSURER SHALL INFORM THE COVERED PERSON AND,  
23 IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
24 REPRESENTATIVE, AND THE DEPARTMENT IN WRITING AND INCLUDE  
25 IN THE NOTICE THE REASONS FOR THE REQUEST'S  
26 INELIGIBILITY.

27           (2) NOTIFICATION UNDER PARAGRAPH (1) (II) SHALL BE  
28 PROVIDED IN A FORM AS SPECIFIED BY THE DEPARTMENT AND INCLUDE  
29 A STATEMENT INFORMING THE COVERED PERSON AND, IF APPLICABLE,  
30 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE THAT AN

1 INSURER'S INITIAL DETERMINATION THAT THE EXTERNAL REVIEW  
2 REQUEST IS INELIGIBLE FOR REVIEW MAY BE APPEALED TO THE  
3 DEPARTMENT.

4 (3) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION  
5 THAT THE REQUEST IS INELIGIBLE FOR REVIEW, THE DEPARTMENT MAY  
6 DETERMINE, BASED UPON THE TERMS OF THE COVERED PERSON'S  
7 HEALTH INSURANCE POLICY, THAT A REQUEST IS ELIGIBLE FOR  
8 EXTERNAL REVIEW UNDER SUBSECTION (B). THE DETERMINATION SHALL  
9 BE BINDING ON THE INSURER AND THE COVERED PERSON AND MAY BE  
10 APPEALED TO THE COMMISSIONER. CONSIDERATION OF THE APPEAL MAY  
11 NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

12 (D) PROCEDURE FOR REVIEW OF ELIGIBLE REQUESTS.--

13 (1) WITHIN ONE BUSINESS DAY OF THE DATE OF RECEIPT OF  
14 NOTICE THAT A REQUEST IS ELIGIBLE FOR EXTERNAL REVIEW  
15 FOLLOWING THE PRELIMINARY REVIEW CONDUCTED UNDER SUBSECTION  
16 (C), THE DEPARTMENT SHALL:

17 (I) ASSIGN AN IRO TO CONDUCT THE EXTERNAL REVIEW  
18 FROM THE LIST OF APPROVED IROS COMPILED AND MAINTAINED BY  
19 THE DEPARTMENT UNDER SECTION 2164.9 AND NOTIFY THE  
20 INSURER OF THE NAME OF THE ASSIGNED IRO.

21 (II) NOTIFY IN WRITING THE COVERED PERSON AND, IF  
22 APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
23 REPRESENTATIVE, OF THE REQUEST'S ELIGIBILITY AND  
24 ACCEPTANCE FOR EXTERNAL REVIEW. THE NOTIFICATION SHALL  
25 INCLUDE A STATEMENT THAT THE COVERED PERSON, OR THE  
26 COVERED PERSON'S AUTHORIZED REPRESENTATIVE, MAY SUBMIT IN  
27 WRITING TO THE ASSIGNED IRO, WITHIN 15 BUSINESS DAYS OF  
28 THE DATE OF RECEIPT OF THE NOTICE PROVIDED UNDER  
29 SUBPARAGRAPH (I), ADDITIONAL INFORMATION THAT THE IRO  
30 SHALL CONSIDER WHEN CONDUCTING THE EXTERNAL REVIEW. THE

1 IRO MAY ACCEPT AND CONSIDER ADDITIONAL INFORMATION  
2 SUBMITTED AFTER ~~FIVE~~ 15 BUSINESS DAYS.

<--

3 (2) THE ASSIGNED IRO SHALL NOT BE BOUND BY A DECISION OR  
4 CONCLUSION REACHED DURING THE INSURER'S INTERNAL CLAIMS AND  
5 APPEAL PROCESS UNDER SECTION 2164.

6 (E) FORWARDING OF REQUIRED DOCUMENTS.--

7 (1) WITHIN FIVE BUSINESS DAYS OF THE DATE OF RECEIPT OF  
8 THE NOTICE PROVIDED UNDER SUBSECTION (D) (1), THE INSURER, OR  
9 A UTILIZATION REVIEW ORGANIZATION DESIGNATED BY THE INSURER,  
10 SHALL PROVIDE TO THE ASSIGNED IRO THE DOCUMENTS AND  
11 INFORMATION CONSIDERED IN MAKING THE ADVERSE BENEFIT  
12 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION.

13 (2) IF THE INSURER, OR A UTILIZATION REVIEW ORGANIZATION  
14 DESIGNATED BY THE INSURER, FAILS TO PROVIDE DOCUMENTS AND  
15 INFORMATION WITHIN THE TIME PERIOD SPECIFIED IN PARAGRAPH  
16 (1), THE IRO MAY PROCEED WITH THE REVIEW, TERMINATE THE  
17 EXTERNAL REVIEW AND MAKE A DECISION TO REVERSE THE ADVERSE  
18 BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION.  
19 WITHIN ONE BUSINESS DAY OF MAKING THE DECISION UNDER  
20 PARAGRAPH (1), THE IRO SHALL NOTIFY THE DEPARTMENT, THE  
21 INSURER, THE COVERED PERSON AND, IF APPLICABLE, THE COVERED  
22 PERSON'S AUTHORIZED REPRESENTATIVE.

23 (F) REVIEW OF INFORMATION.--

24 (1) THE ASSIGNED IRO SHALL REVIEW ALL OF THE INFORMATION  
25 AND DOCUMENTS RECEIVED UNDER SUBSECTION (E) AND OTHER  
26 INFORMATION SUBMITTED IN WRITING TO THE IRO BY THE COVERED  
27 PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE  
28 UNDER SUBSECTION (D) (1) (II).

29 (2) WITHIN ONE BUSINESS DAY OF RECEIPT OF INFORMATION  
30 SUBMITTED BY THE COVERED PERSON OR THE COVERED PERSON'S



1 AUTHORIZED REPRESENTATIVE, THE ASSIGNED IRO SHALL FORWARD THE  
2 INFORMATION TO THE INSURER.

3 (G) RECONSIDERATION BY INSURER.--

4 (1) UPON RECEIPT OF THE INFORMATION, IF ANY, REQUIRED TO  
5 BE FORWARDED UNDER SUBSECTION (F) (2), THE INSURER MAY  
6 RECONSIDER AN ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE  
7 BENEFIT DETERMINATION THAT IS THE SUBJECT OF THE EXTERNAL  
8 REVIEW.

9 (2) RECONSIDERATION BY THE INSURER OF AN ADVERSE BENEFIT  
10 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION UNDER  
11 PARAGRAPH (1) MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

12 (3) THE EXTERNAL REVIEW MAY BE TERMINATED WITHOUT AN IRO  
13 DETERMINATION ONLY IF THE INSURER DECIDES, UPON COMPLETION OF  
14 THE INSURER'S RECONSIDERATION, TO REVERSE THE INSURER'S  
15 ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
16 DETERMINATION AND PROVIDE COVERAGE OR PAYMENT FOR THE  
17 RECOMMENDED HEALTH CARE SERVICE THAT IS THE SUBJECT OF THE  
18 EXTERNAL REVIEW.

19 (4) WITHIN ONE BUSINESS DAY OF MAKING THE DECISION TO  
20 REVERSE ITS ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE  
21 BENEFIT DETERMINATION, AS PROVIDED IN PARAGRAPH (3), THE  
22 INSURER SHALL NOTIFY THE DEPARTMENT, THE ASSIGNED IRO, THE  
23 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S  
24 AUTHORIZED REPRESENTATIVE, IN WRITING OF ITS DECISION.

25 (5) THE ASSIGNED IRO SHALL TERMINATE THE EXTERNAL REVIEW  
26 UPON RECEIPT OF THE NOTICE FROM THE INSURER SENT UNDER  
27 PARAGRAPH (4).

28 (H) FACTORS TO BE CONSIDERED.--IN ADDITION TO THE DOCUMENTS  
29 AND INFORMATION PROVIDED UNDER SUBSECTION (E), THE ASSIGNED IRO,  
30 TO THE EXTENT THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE

1 IRO CONSIDERS THEM APPROPRIATE, SHALL CONSIDER THE FOLLOWING  
2 INFORMATION IN REACHING A DECISION:

3 (1) THE COVERED PERSON'S MEDICAL RECORDS.

4 (2) THE ATTENDING HEALTH CARE PROVIDER'S RECOMMENDATION.

5 (3) CONSULTING REPORTS FROM APPROPRIATE HEALTH CARE  
6 PROVIDERS AND OTHER DOCUMENTS SUBMITTED BY THE INSURER, THE  
7 COVERED PERSON<sup>7</sup> OR THE COVERED PERSON'S AUTHORIZED <--  
8 REPRESENTATIVE OR THE COVERED PERSON'S TREATING PROVIDER. <--

9 (4) THE TERMS OF COVERAGE UNDER THE COVERED PERSON'S  
10 HEALTH INSURANCE POLICY TO ENSURE THAT THE IRO'S DECISION IS  
11 NOT CONTRARY TO THE TERMS OF COVERAGE.

12 (5) THE MOST APPROPRIATE PRACTICE GUIDELINES, WHICH  
13 SHALL INCLUDE APPLICABLE EVIDENCE-BASED STANDARDS AND MAY  
14 INCLUDE OTHER PRACTICE GUIDELINES DEVELOPED BY THE FEDERAL  
15 GOVERNMENT OR NATIONAL OR PROFESSIONAL MEDICAL SOCIETIES,  
16 BOARDS AND ASSOCIATIONS.

17 (6) APPLICABLE CLINICAL REVIEW CRITERIA DEVELOPED AND  
18 USED BY THE INSURER OR A UTILIZATION REVIEW ORGANIZATION  
19 DESIGNATED BY THE INSURER.

20 (7) THE ~~OPTION~~ OPINION OF THE IRO'S CLINICAL REVIEWER OR <--  
21 REVIEWERS AFTER CONSIDERING THE INFORMATION UNDER PARAGRAPHS  
22 (1), (2), (3), (4), (5) AND (6).

23 (I) NOTICE OF DECISION.--

24 (1) WITHIN 45 DAYS OF THE DATE OF RECEIPT OF THE REQUEST  
25 FOR AN EXTERNAL REVIEW, THE ASSIGNED IRO SHALL PROVIDE  
26 WRITTEN NOTICE OF THE IRO'S DECISION TO UPHOLD OR REVERSE THE  
27 ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT  
28 DETERMINATION TO:

29 (I) THE COVERED PERSON.

30 (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED

1           REPRESENTATIVE.

2           (III) THE INSURER.

3           (IV) THE DEPARTMENT.

4           (2) THE IRO SHALL INCLUDE IN THE NOTICE UNDER PARAGRAPH  
5           (1):

6           (I) A GENERAL DESCRIPTION OF THE REASON FOR THE  
7           REQUEST FOR EXTERNAL REVIEW.

8           (II) THE DATE THE IRO RECEIVED THE ASSIGNMENT FROM  
9           THE DEPARTMENT TO CONDUCT THE EXTERNAL REVIEW.

10          (III) THE DATE THE EXTERNAL REVIEW WAS CONDUCTED.

11          (IV) THE DATE OF THE IRO'S DECISION.

12          (V) THE PRINCIPAL REASON OR REASONS FOR THE IRO'S  
13          DECISION, INCLUDING WHAT APPLICABLE EVIDENCE-BASED  
14          STANDARDS WERE CONSIDERED IN REACHING THE IRO'S DECISION.

15          (VI) THE RATIONALE FOR THE IRO'S DECISION.

16          (VII) REFERENCES TO THE EVIDENCE OR DOCUMENTATION,  
17          INCLUDING EVIDENCE-BASED STANDARDS, CONSIDERED IN  
18          REACHING THE IRO'S DECISION.

19          (3) UPON RECEIPT OF A NOTICE OF A DECISION UNDER  
20          PARAGRAPH (1) REVERSING THE ADVERSE BENEFIT DETERMINATION OR  
21          FINAL ADVERSE BENEFIT DETERMINATION, THE INSURER SHALL WITHIN  
22          24 HOURS APPROVE THE COVERAGE THAT WAS THE SUBJECT OF THE  
23          ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
24          DETERMINATION.

25          (J) ASSIGNMENT OF IRO.--THE DEPARTMENT SHALL ASSIGN ON A  
26          RANDOM BASIS AN APPROVED IRO FROM THOSE QUALIFIED TO CONDUCT THE  
27          PARTICULAR EXTERNAL REVIEW BASED ON THE NATURE OF THE HEALTH  
28          CARE SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT  
29          DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, AND SHALL  
30          CONSIDER THE CONFLICT-OF-INTEREST CONCERNS UNDER SECTION

1 2164.10(D).

2 SECTION 2164.6. EXPEDITED EXTERNAL REVIEW.

3 (A) REQUEST FOR REVIEW.--EXCEPT AS PROVIDED IN SUBSECTION  
4 (F), A COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED  
5 REPRESENTATIVE MAY MAKE A REQUEST FOR EXPEDITED EXTERNAL REVIEW  
6 WITH THE DEPARTMENT AT THE TIME THE COVERED PERSON RECEIVES:

7 (1) AN ADVERSE BENEFIT DETERMINATION, IF EITHER OF THE  
8 FOLLOWING APPLIES:

9 (I) THE ADVERSE BENEFIT DETERMINATION INVOLVES A  
10 MEDICAL CONDITION OF THE COVERED PERSON FOR WHICH THE  
11 TIME FRAME FOR COMPLETION OF AN EXPEDITED INTERNAL REVIEW  
12 UNDER SECTION 2164 WOULD SERIOUSLY JEOPARDIZE THE LIFE OR  
13 HEALTH OF THE COVERED PERSON OR WOULD JEOPARDIZE THE  
14 COVERED PERSON'S ABILITY TO REGAIN MAXIMUM FUNCTION.

15 (II) THE COVERED PERSON OR THE COVERED PERSON'S  
16 AUTHORIZED REPRESENTATIVE HAS FILED A REQUEST FOR AN  
17 EXPEDITED INTERNAL REVIEW OF AN ADVERSE BENEFIT  
18 DETERMINATION UNDER SECTION 2164.

19 (2) A FINAL ADVERSE BENEFIT DETERMINATION IF EITHER OF  
20 THE FOLLOWING APPLY:

21 (I) THE COVERED PERSON HAS A MEDICAL CONDITION FOR  
22 WHICH THE TIME FRAME FOR COMPLETION OF A STANDARD  
23 EXTERNAL REVIEW UNDER SECTION 2164.5 WOULD SERIOUSLY  
24 JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR  
25 WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN  
26 MAXIMUM FUNCTION.

27 (II) THE FINAL ADVERSE BENEFIT DETERMINATION  
28 CONCERNS AN ADMISSION, AVAILABILITY OF CARE, CONTINUED  
29 STAY OR HEALTH CARE SERVICE FOR WHICH THE COVERED PERSON  
30 RECEIVED EMERGENCY SERVICES BUT HAS NOT BEEN DISCHARGED

1           FROM A FACILITY.

2           (B) PRELIMINARY REVIEW OF REQUEST.--

3           (1) UPON RECEIPT OF A REQUEST FOR AN EXPEDITED EXTERNAL  
4 REVIEW, THE DEPARTMENT SHALL, WITHIN 24 HOURS, SEND A COPY OF  
5 THE REQUEST TO THE INSURER.

6           (2) WITHIN 24 HOURS UPON RECEIPT OF A REQUEST UNDER  
7 PARAGRAPH (1), THE INSURER SHALL DETERMINE WHETHER THE  
8 REQUEST MEETS THE REQUIREMENTS FOR REVIEW UNDER SECTION  
9 2164.5(B). THE INSURER SHALL, WITHIN 24 HOURS, NOTIFY THE  
10 DEPARTMENT, THE COVERED PERSON AND, IF APPLICABLE, THE  
11 COVERED PERSON'S AUTHORIZED REPRESENTATIVE OF THE INSURER'S  
12 ELIGIBILITY DETERMINATION.

13           (3) NOTIFICATION PROVIDED UNDER PARAGRAPH (2) SHALL BE  
14 PROVIDED IN A FORM AS SPECIFIED BY THE DEPARTMENT AND INCLUDE  
15 A STATEMENT INFORMING THE COVERED PERSON AND, IF APPLICABLE,  
16 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE THAT AN  
17 INSURER'S INITIAL DETERMINATION THAT THE EXTERNAL REVIEW  
18 REQUEST IS INELIGIBLE FOR REVIEW MAY BE APPEALED TO THE  
19 DEPARTMENT.

20           (4) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION  
21 THAT THE REQUEST IS INELIGIBLE FOR REVIEW, THE DEPARTMENT MAY  
22 DECIDE, BASED UPON THE TERMS OF THE COVERED PERSON'S HEALTH  
23 INSURANCE POLICY, THAT A REQUEST IS ELIGIBLE FOR EXTERNAL  
24 REVIEW UNDER SECTION 2164.5(B). THE DEPARTMENT'S DECISION  
25 SHALL BE BINDING ON THE INSURER AND THE COVERED PERSON AND  
26 MAY BE APPEALED TO THE COMMISSIONER. CONSIDERATION OF AN  
27 APPEAL MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

28           (5) UPON RECEIPT OF THE NOTICE THAT THE REQUEST MEETS  
29 THE REQUIREMENTS FOR REVIEW, THE DEPARTMENT SHALL, WITHIN 24  
30 HOURS, ASSIGN AN IRO TO CONDUCT THE EXPEDITED EXTERNAL REVIEW

1 FROM THE LIST OF APPROVED IROS COMPILED AND MAINTAINED BY THE  
2 DEPARTMENT UNDER SECTION 2164.9. THE DEPARTMENT SHALL, WITHIN  
3 24 HOURS, NOTIFY THE INSURER OF THE NAME OF THE ASSIGNED IRO.

4 (6) IN REACHING A DECISION IN ACCORDANCE WITH SUBSECTION  
5 (E), THE ASSIGNED IRO SHALL NOT BE BOUND BY A DECISION OR  
6 CONCLUSION REACHED DURING THE INTERNAL ADVERSE BENEFIT  
7 DETERMINATION PROCESS FOR AN INSURER UNDER SECTION 2164.

8 (C) FORWARDING OF REQUIRED DOCUMENTS.--UPON RECEIPT OF  
9 DEPARTMENTAL NOTICE OF THE NAME OF THE IRO ASSIGNED TO CONDUCT  
10 THE EXPEDITED EXTERNAL REVIEW UNDER SUBSECTION (B) (5), THE  
11 INSURER OR AN IRO DESIGNATED BY THE INSURER SHALL PROVIDE TO THE  
12 ASSIGNED IRO THE DOCUMENTS AND INFORMATION CONSIDERED IN MAKING  
13 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
14 DETERMINATION BY ONE OF THE FOLLOWING METHODS:

15 (1) ELECTRONICALLY.

16 (2) BY TELEPHONE.

17 (3) BY FACSIMILE.

18 (4) BY ANY OTHER AVAILABLE EXPEDITIOUS METHOD.

19 (D) FACTORS TO BE CONSIDERED.--IN ADDITION TO THE DOCUMENTS  
20 AND INFORMATION PROVIDED UNDER SUBSECTION (C), THE ASSIGNED IRO,  
21 TO THE EXTENT THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE  
22 IRO CONSIDERS THEM APPROPRIATE, SHALL CONSIDER THE FOLLOWING  
23 INFORMATION IN REACHING A DECISION:

24 (1) THE COVERED PERSON'S MEDICAL RECORDS.

25 (2) THE ATTENDING HEALTH CARE PROVIDER'S RECOMMENDATION.

26 (3) CONSULTING REPORTS FROM APPROPRIATE HEALTH CARE  
27 PROVIDERS AND OTHER DOCUMENTS SUBMITTED BY THE INSURER, THE  
28 COVERED PERSON, OR THE COVERED PERSON'S AUTHORIZED <--  
29 REPRESENTATIVE OR THE COVERED PERSON'S TREATING PROVIDER. <--

30 (4) THE TERMS OF COVERAGE UNDER THE COVERED PERSON'S

1 HEALTH INSURANCE POLICY TO ENSURE THAT THE IRO'S DECISION IS  
2 NOT CONTRARY TO THE TERMS OF COVERAGE.

3 (5) THE MOST APPROPRIATE PRACTICE GUIDELINES, WHICH  
4 SHALL INCLUDE APPLICABLE EVIDENCE-BASED STANDARDS AND MAY  
5 INCLUDE ANY OTHER PRACTICE GUIDELINES DEVELOPED BY THE  
6 FEDERAL GOVERNMENT OR NATIONAL OR PROFESSIONAL MEDICAL  
7 SOCIETIES, BOARDS AND ASSOCIATIONS.

8 (6) APPLICABLE CLINICAL REVIEW CRITERIA DEVELOPED AND  
9 USED BY THE INSURER OR A UTILIZATION REVIEW ORGANIZATION  
10 DESIGNATED BY THE INSURER.

11 (7) THE OPINION OF THE IRO'S CLINICAL REVIEWER OR  
12 REVIEWERS AFTER CONSIDERING THE INFORMATION UNDER PARAGRAPHS  
13 (1), (2), (3), (4), (5) AND (6).

14 (E) NOTICE OF DECISION.--

15 (1) AS EXPEDITIOUSLY AS THE COVERED PERSON'S MEDICAL  
16 CONDITION OR CIRCUMSTANCES REQUIRE, BUT IN NO EVENT MORE THAN  
17 72 HOURS AFTER THE DATE OF RECEIPT OF THE REQUEST FOR AN  
18 EXPEDITED EXTERNAL REVIEW THAT MEETS THE REVIEWABILITY  
19 REQUIREMENTS UNDER SECTION 2164.5(B), THE ASSIGNED IRO SHALL  
20 PROVIDE NOTICE OF THE IRO'S DECISION TO UPHOLD OR REVERSE THE  
21 ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT  
22 DETERMINATION TO:

23 (I) THE COVERED PERSON.

24 (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
25 REPRESENTATIVE.

26 (III) THE INSURER.

27 (IV) THE DEPARTMENT.

28 (2) IF THE NOTICE PROVIDED UNDER PARAGRAPH (1) IS NOT IN  
29 WRITING, WITHIN 48 HOURS OF THE DATE OF PROVIDING THAT  
30 NOTICE, THE ASSIGNED IRO SHALL PROVIDE WRITTEN NOTICE OF THE

IRO'S DECISION TO UPHOLD OR REVERSE THE ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT DETERMINATION TO:

(I) THE COVERED PERSON.

(II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE.

(III) THE INSURER.

(IV) THE DEPARTMENT.

(3) THE IRO SHALL INCLUDE IN THE NOTICE UNDER PARAGRAPH (2):

(I) A GENERAL DESCRIPTION OF THE REASON FOR THE REQUEST FOR EXTERNAL REVIEW.

(II) THE DATE THE IRO RECEIVED THE ASSIGNMENT FROM THE DEPARTMENT TO CONDUCT THE EXTERNAL REVIEW.

(III) THE DATE THE EXTERNAL REVIEW WAS CONDUCTED.

(IV) THE DATE OF THE IRO'S DECISION.

(V) THE PRINCIPAL REASON OR ~~REASON~~ REASONS FOR THE IRO'S DECISION, INCLUDING APPLICABLE EVIDENCE-BASED STANDARDS CONSIDERED IN REACHING THE IRO'S DECISION.

<--

(VI) THE RATIONALE FOR THE IRO'S DECISION.

(VII) REFERENCES TO THE EVIDENCE OR DOCUMENTATION, INCLUDING EVIDENCE-BASED STANDARDS, CONSIDERED IN REACHING THE IRO'S DECISION.

(4) UPON RECEIPT OF A NOTICE OF A DECISION UNDER PARAGRAPH (1) REVERSING THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, THE INSURER SHALL, WITHIN 24 HOURS, APPROVE THE COVERAGE THAT WAS THE SUBJECT OF THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION.

(F) PROHIBITION OF RETROSPECTIVE EXPEDITED EXTERNAL REVIEW.--AN EXPEDITED EXTERNAL REVIEW MAY NOT BE PROVIDED FOR



1 RETROSPECTIVE ADVERSE BENEFIT DETERMINATIONS OR FINAL ADVERSE <--  
2 BENEFIT DETERMINATIONS.

3 (G) ASSIGNMENT OF IRO.--THE DEPARTMENT SHALL ASSIGN ON A  
4 RANDOM BASIS AN APPROVED IRO AMONG THOSE QUALIFIED TO CONDUCT  
5 THE PARTICULAR EXTERNAL REVIEW BASED ON THE NATURE OF THE HEALTH  
6 CARE SERVICE THAT IS SUBJECT OF THE ADVERSE BENEFIT  
7 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, AND SHALL  
8 CONSIDER THE CONFLICT-OF-INTEREST CONCERNS UNDER SECTION  
9 2164.10(D).

10 SECTION 2164.7. EXTERNAL REVIEW OF EXPERIMENTAL OR  
11 INVESTIGATIONAL TREATMENT ADVERSE BENEFIT  
12 DETERMINATIONS.

13 (A) REQUEST FOR REVIEW.--

14 (1) WITHIN FOUR MONTHS OF THE DATE OF RECEIPT OF A  
15 NOTICE OF AN ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE  
16 BENEFIT DETERMINATION UNDER SECTION 2164.2 THAT INVOLVES A  
17 DENIAL OF COVERAGE BASED ON A DETERMINATION THAT THE HEALTH  
18 CARE SERVICES RECOMMENDED OR REQUESTED ARE EXPERIMENTAL OR  
19 INVESTIGATIONAL, A COVERED PERSON, OR THE COVERED PERSON'S  
20 AUTHORIZED REPRESENTATIVE, MAY FILE A REQUEST FOR EXTERNAL  
21 REVIEW WITH THE DEPARTMENT.

22 (2) A COVERED PERSON, OR THE COVERED PERSON'S AUTHORIZED  
23 REPRESENTATIVE, MAY MAKE AN ORAL REQUEST FOR EXPEDITED  
24 EXTERNAL REVIEW OF THE ADVERSE BENEFIT DETERMINATION OR FINAL  
25 ADVERSE BENEFIT DETERMINATION UNDER PARAGRAPH (1) IF THE  
26 COVERED PERSON'S TREATING HEALTH CARE PROVIDER ~~CERTIFICATES~~ <--  
27 CERTIFIES IN WRITING THAT THE RECOMMENDED OR REQUESTED HEALTH <--  
28 CARE SERVICES THAT ARE THE SUBJECT OF THE REQUEST WOULD BE  
29 SIGNIFICANTLY LESS EFFECTIVE IF NOT PROMPTLY INITIATED. UPON  
30 RECEIPT OF A REQUEST FOR AN EXPEDITED EXTERNAL REVIEW, THE

1 DEPARTMENT SHALL NOTIFY THE INSURER WITHIN 24 HOURS.

2 (3) WITH RESPECT TO NOTICE OF AN INSURER'S ELIGIBILITY  
3 DETERMINATION:

4 (I) UPON NOTICE OF THE REQUEST FOR EXPEDITED  
5 EXTERNAL REVIEW, THE INSURER SHALL IMMEDIATELY DETERMINE  
6 WHETHER THE REQUEST MEETS THE REQUIREMENTS FOR REVIEW  
7 UNDER SUBSECTION ~~(B)~~ SECTION 2164.5(B). THE INSURER <--  
8 SHALL, WITHIN 24 HOURS, NOTIFY THE DEPARTMENT, THE  
9 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S  
10 AUTHORIZED REPRESENTATIVE, OF THE INSURER'S ELIGIBILITY  
11 DETERMINATION.

12 (II) THE DEPARTMENT MAY SPECIFY THE FORM FOR THE  
13 INSURER'S NOTICE OF INITIAL DETERMINATION UNDER  
14 SUBPARAGRAPH (I) AND ANY SUPPORTING INFORMATION TO BE  
15 INCLUDED IN THE NOTICE.

16 (III) THE NOTICE OF INITIAL DETERMINATION UNDER  
17 SUBPARAGRAPH (I) SHALL INCLUDE A STATEMENT INFORMING THE  
18 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S  
19 AUTHORIZED REPRESENTATIVE, OF AN INSURER'S INITIAL  
20 DETERMINATION THAT THE EXTERNAL REVIEW REQUEST IS  
21 INELIGIBLE FOR REVIEW AND THAT THE EXTERNAL REVIEW  
22 REQUEST MAY BE APPEALED TO THE DEPARTMENT.

23 ~~(3)~~ (4) NOTWITHSTANDING AN INSURER'S INITIAL <--  
24 DETERMINATION, THE DEPARTMENT MAY DECIDE THAT A REQUEST IS  
25 ELIGIBLE FOR EXTERNAL REVIEW UNDER PARAGRAPH ~~(2)~~ SECTION <--  
26 2164.5(B) AND REQUIRE THAT THE REQUEST BE REFERRED FOR  
27 EXTERNAL REVIEW. THE DEPARTMENT'S DECISION SHALL BE MADE IN  
28 ACCORDANCE WITH THE TERMS OF THE COVERED PERSON'S HEALTH  
29 INSURANCE POLICY AND SHALL BE SUBJECT TO ALL APPLICABLE  
30 PROVISIONS OF THIS SUBDIVISION. THE DEPARTMENT'S DECISION

1 SHALL BE BINDING ON THE INSURER AND THE COVERED PERSON AND  
2 MAY BE APPEALED TO THE COMMISSIONER. CONSIDERATION OF AN  
3 APPEAL MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

4 ~~(4)~~ (5) UPON RECEIPT OF A NOTICE UNDER PARAGRAPH (2) <--  
5 THAT THE EXPEDITED EXTERNAL REVIEW REQUEST MEETS THE <--  
6 REVIEWABILITY REQUIREMENTS OF SUBSECTION (B) (2), THE  
7 DEPARTMENT SHALL, WITHIN 24 HOURS, ASSIGN AN IRO TO REVIEW  
8 THE EXPEDITED REQUEST FROM THE LIST OF APPROVED IROS COMPILED  
9 AND MAINTAINED BY THE DEPARTMENT UNDER SECTION 2164.9 AND  
10 NOTIFY THE INSURER OF THE NAME OF THE ASSIGNED IRO. THE  
11 INSURER, OR A UTILIZATION REVIEW ORGANIZATION DESIGNATED BY  
12 THE INSURER, SHALL THEN PROVIDE OR TRANSMIT ALL NECESSARY  
13 DOCUMENTS AND INFORMATION CONSIDERED IN MAKING THE ADVERSE  
14 BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION  
15 TO THE ASSIGNED IRO:

16 (I) ELECTRONICALLY.

17 (II) BY TELEPHONE.

18 (III) BY FACSIMILE.

19 (IV) BY ANY OTHER AVAILABLE EXPEDITIOUS METHOD.

20 (B) PRELIMINARY REVIEW REQUEST.--

21 (1) EXCEPT FOR A REQUEST FOR AN EXPEDITED EXTERNAL  
22 REVIEW MADE UNDER SUBSECTION (A) (2), WITHIN ONE BUSINESS DAY  
23 OF THE DATE OF RECEIPT OF THE REQUEST FOR EXTERNAL REVIEW,  
24 THE DEPARTMENT SHALL NOTIFY THE INSURER OF THE DEPARTMENT'S  
25 RECEIPT OF THE REQUEST.

26 (2) WITHIN FIVE BUSINESS DAYS OF THE DATE OF RECEIPT OF  
27 THE NOTICE SENT UNDER PARAGRAPH (1), THE INSURER SHALL  
28 CONDUCT AND COMPLETE A PRELIMINARY REVIEW OF THE REQUEST TO  
29 DETERMINE WHETHER:

30 (I) THE INDIVIDUAL IS OR WAS A COVERED PERSON UNDER

1 THE HEALTH INSURANCE POLICY AT THE TIME THE HEALTH CARE  
2 SERVICES WERE RECOMMENDED OR REQUESTED OR, IN THE CASE OF  
3 A RETROSPECTIVE REVIEW, WAS A COVERED PERSON UNDER THE  
4 HEALTH INSURANCE POLICY AT THE TIME THE HEALTH CARE  
5 SERVICES WERE PROVIDED.

6 (II) THE RECOMMENDED OR REQUESTED HEALTH CARE  
7 SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT  
8 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION:

9 (A) IS A COVERED BENEFIT UNDER THE COVERED  
10 PERSON'S HEALTH INSURANCE POLICY, EXCEPT FOR THE  
11 INSURER'S DETERMINATION THAT THE HEALTH CARE SERVICE  
12 IS EXPERIMENTAL OR INVESTIGATIONAL FOR A PARTICULAR  
13 MEDICAL CONDITION.

14 (B) IS NOT EXPLICITLY LISTED AS AN EXCLUDED  
15 BENEFIT UNDER THE COVERED PERSON'S HEALTH INSURANCE  
16 POLICY.

17 (III) THE COVERED PERSON'S TREATING HEALTH CARE  
18 PROVIDER HAS CERTIFIED THAT ONE OF THE FOLLOWING  
19 SITUATIONS IS APPLICABLE:

20 (A) STANDARD HEALTH CARE SERVICES HAVE NOT BEEN  
21 EFFECTIVE IN IMPROVING THE CONDITION OF THE COVERED  
22 PERSON.

23 (B) STANDARD HEALTH CARE SERVICES ARE NOT  
24 MEDICALLY APPROPRIATE FOR THE COVERED PERSON.

25 (C) THERE ARE NO AVAILABLE STANDARD HEALTH CARE  
26 SERVICES COVERED UNDER THE HEALTH INSURANCE POLICY  
27 THAT ARE MORE BENEFICIAL THAN THE RECOMMENDED OR  
28 REQUESTED HEALTH CARE SERVICES DESCRIBED IN  
29 SUBPARAGRAPH (IV).

30 (IV) THE COVERED PERSON'S TREATING HEALTH CARE

1 PROVIDER EITHER:

2 (A) HAS RECOMMENDED HEALTH CARE SERVICES THAT  
3 THE HEALTH CARE PROVIDER CERTIFIES, IN WRITING, ARE  
4 LIKELY TO BE MORE BENEFICIAL TO THE COVERED PERSON,  
5 IN THE HEALTH CARE PROVIDER'S OPINION, THAN AVAILABLE  
6 STANDARD HEALTH CARE SERVICES.

7 (B) HAS CERTIFIED IN WRITING THAT SCIENTIFICALLY  
8 VALID STUDIES USING ACCEPTED PROTOCOLS DEMONSTRATE  
9 THAT THE HEALTH CARE SERVICES REQUESTED BY THE  
10 COVERED PERSON WHO IS THE SUBJECT OF THE ADVERSE  
11 BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
12 DETERMINATION, ARE LIKELY TO BE MORE BENEFICIAL TO  
13 THE COVERED PERSON THAN ANY AVAILABLE STANDARD HEALTH  
14 CARE SERVICES, WHEN THE TREATING HEALTH CARE PROVIDER  
15 IS A LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE  
16 PHYSICIAN QUALIFIED TO PRACTICE IN THE AREA OF  
17 MEDICINE APPROPRIATE TO TREAT THE COVERED PERSON'S  
18 CONDITION.

19 (V) THE COVERED PERSON HAS EXHAUSTED THE INSURER'S  
20 INTERNAL CLAIMS AND APPEAL PROCESS UNDER SECTION 2164,  
21 UNLESS THE COVERED PERSON IS NOT REQUIRED TO EXHAUST THE  
22 INSURER'S INTERNAL APPEAL PROCESS UNDER SECTION 2164.4.

23 (VI) THE COVERED PERSON HAS PROVIDED ALL THE  
24 INFORMATION AND FORMS REQUIRED BY THE DEPARTMENT THAT ARE  
25 NECESSARY TO PROCESS AN EXTERNAL REVIEW, INCLUDING THE  
26 RELEASE FORM PROVIDED UNDER SECTION 2164.2(B).

27 (C) NOTICE OF INITIAL DETERMINATION.--

28 (1) WITHIN ONE BUSINESS DAY OF COMPLETION OF THE  
29 PRELIMINARY REVIEW, THE INSURER SHALL NOTIFY THE DEPARTMENT  
30 AND COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S

1 AUTHORIZED REPRESENTATIVE, IN WRITING WHETHER THE REQUEST IS  
2 COMPLETE AND ELIGIBLE FOR EXTERNAL REVIEW.

3 (2) IF THE REQUEST:

4 (I) IS NOT COMPLETE, THE INSURER SHALL INFORM THE  
5 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S  
6 AUTHORIZED REPRESENTATIVE, AND THE DEPARTMENT IN WRITING <--  
7 AND INCLUDE IN THE NOTICE WHAT INFORMATION OR MATERIALS  
8 ARE NEEDED TO MAKE THE REQUEST COMPLETE.

9 (II) IS NOT ELIGIBLE FOR EXTERNAL REVIEW, THE  
10 INSURER SHALL INFORM THE COVERED PERSON AND, IF  
11 APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
12 REPRESENTATIVE, AND THE DEPARTMENT IN WRITING AND INCLUDE <--  
13 IN THE NOTICE THE REASONS FOR THE REQUEST'S  
14 INELIGIBILITY.

15 (3) NOTIFICATION PROVIDED UNDER PARAGRAPH (2) SHALL BE  
16 PROVIDED IN A FORM SPECIFIED BY THE DEPARTMENT AND INCLUDE A  
17 STATEMENT INFORMING THE COVERED PERSON AND, IF APPLICABLE,  
18 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE, OF AN <--  
19 INSURER'S INITIAL DETERMINATION THAT THE REQUEST IS  
20 INELIGIBLE FOR EXTERNAL REVIEW AND THAT THE EXTERNAL REVIEW  
21 REQUEST MAY BE APPEALED TO THE DEPARTMENT.

22 (4) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION  
23 THAT THE REQUEST IS INELIGIBLE FOR REVIEW, THE DEPARTMENT MAY  
24 DETERMINE, BASED UPON THE TERMS OF THE COVERED PERSON'S  
25 HEALTH INSURANCE POLICY, THAT THE REQUEST IS ELIGIBLE FOR  
26 EXTERNAL REVIEW UNDER SECTION 2164.5. THE DETERMINATION SHALL  
27 BE BINDING ON THE INSURER AND THE COVERED PERSON AND MAY BE  
28 APPEALED TO THE COMMISSIONER. CONSIDERATION OF THE APPEAL MAY  
29 NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

30 (5) WHEN A REQUEST IS DETERMINED TO BE ELIGIBLE FOR

1 EXTERNAL REVIEW, THE INSURER SHALL NOTIFY THE DEPARTMENT, THE  
2 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S  
3 AUTHORIZED REPRESENTATIVE.

4 (D) PROCEDURE FOR REVIEW OF REQUESTS ELIGIBLE FOR EXTERNAL  
5 REVIEW.--

6 (1) WITHIN ONE BUSINESS DAY OF THE DATE OF RECEIPT OF  
7 NOTICE THAT A REQUEST IS ELIGIBLE FOR EXTERNAL REVIEW  
8 FOLLOWING THE PRELIMINARY REVIEW CONDUCTED UNDER SUBSECTION  
9 ~~(C)~~ (A) (4) OR (C) (4), THE DEPARTMENT SHALL:

<--

10 (I) ASSIGN AN IRO TO CONDUCT THE EXTERNAL REVIEW  
11 FROM THE LIST OF APPROVED IROS COMPILED AND MAINTAINED BY  
12 THE DEPARTMENT UNDER SECTION 2164.9 AND NOTIFY THE  
13 INSURER OF THE NAME OF THE ASSIGNED IRO.

14 (II) NOTIFY IN WRITING THE COVERED PERSON AND, IF  
15 APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
16 REPRESENTATIVE OF THE REQUEST'S ELIGIBILITY AND  
17 ACCEPTANCE FOR EXTERNAL REVIEW. THE NOTIFICATION SHALL  
18 INCLUDE A STATEMENT THAT THE COVERED PERSON, OR THE  
19 COVERED PERSON'S AUTHORIZED REPRESENTATIVE, MAY SUBMIT IN  
20 WRITING TO THE ASSIGNED IRO, WITHIN FIVE BUSINESS DAYS OF  
21 THE DATE OF RECEIPT OF THE NOTICE PROVIDED UNDER  
22 SUBPARAGRAPH (I), ADDITIONAL INFORMATION THAT THE IRO  
23 SHALL CONSIDER WHEN CONDUCTING THE EXTERNAL REVIEW. THE  
24 IRO MAY ACCEPT AND CONSIDER ADDITIONAL INFORMATION  
25 SUBMITTED AFTER FIVE BUSINESS DAYS.

26 (2) WITHIN ONE BUSINESS DAY OF THE RECEIPT OF THE NOTICE  
27 OF ASSIGNMENT TO CONDUCT THE EXTERNAL REVIEW UNDER PARAGRAPH  
28 (1), THE ASSIGNED IRO SHALL:

29 (I) SELECT ONE OR MORE CLINICAL REVIEWERS UNDER  
30 PARAGRAPH (3) TO CONDUCT THE EXTERNAL REVIEW.

1           (II) BASED ON THE OPINION OR OPINIONS OF THE  
2           CLINICAL REVIEWER OR REVIEWERS, MAKE A DECISION TO UPHOLD  
3           OR REVERSE THE ADVERSE BENEFIT DETERMINATION OR FINAL  
4           ADVERSE BENEFIT DETERMINATION.

5           (3) IN SELECTING A CLINICAL REVIEWER, THE ASSIGNED IRO  
6           SHALL SELECT A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO  
7           MEETS THE MINIMUM QUALIFICATIONS DESCRIBED IN SECTION ~~2611.1~~ <--  
8           2164.10 AND, THROUGH CLINICAL EXPERIENCE IN THE PAST THREE <--  
9           YEARS, HAS EXPERTISE IN THE TREATMENT OF THE COVERED PERSON'S  
10           CONDITION AND IS KNOWLEDGEABLE ABOUT THE RECOMMENDED OR  
11           REQUESTED HEALTH CARE SERVICE. THE COVERED PERSON, THE  
12           COVERED PERSON'S AUTHORIZED REPRESENTATIVE AND, IF  
13           APPLICABLE, THE INSURER, MAY NOT CHOOSE OR CONTROL THE CHOICE <--  
14           OF THE PHYSICIAN OR OTHER HEALTH CARE PROVIDER TO BE SELECTED  
15           TO CONDUCT THE EXTERNAL REVIEW.

16           (4) IN ACCORDANCE WITH SUBSECTION ~~(E)~~ (H), EACH CLINICAL <--  
17           REVIEWER SHALL PROVIDE A WRITTEN OPINION TO THE ASSIGNED IRO  
18           REGARDING WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE  
19           SERVICE SHOULD BE COVERED.

20           (5) THE ASSIGNED CLINICAL REVIEWER IS NOT BOUND BY A  
21           DECISION OR CONCLUSION REACHED DURING THE INSURER'S INTERNAL  
22           CLAIMS AND APPEAL PROCESS UNDER SECTION 2164.

23           (E) FORWARDING OF REQUIRED DOCUMENTS.--

24           (1) WITHIN FIVE BUSINESS DAYS OF THE DATE OF RECEIPT OF  
25           THE NOTICE PROVIDED UNDER SUBSECTION (D) (1), THE INSURER, OR  
26           A UTILIZATION REVIEW ORGANIZATION DESIGNATED BY THE INSURER,  
27           SHALL PROVIDE TO THE ASSIGNED IRO THE DOCUMENTS AND  
28           INFORMATION CONSIDERED IN MAKING THE ADVERSE BENEFIT  
29           DETERMINATION OR THE FINAL ADVERSE BENEFIT DETERMINATION.

30           (2) EXCEPT AS PROVIDED IN PARAGRAPH (3), FAILURE BY THE



1 INSURER, OR BY A UTILIZATION REVIEW ORGANIZATION DESIGNATED  
2 BY THE INSURER, TO PROVIDE THE DOCUMENTS AND INFORMATION  
3 WITHIN THE TIME PERIOD SPECIFIED IN PARAGRAPH (1) MAY NOT  
4 DELAY THE CONDUCT OF THE EXTERNAL REVIEW.

5 (3) IF THE INSURER, OR A UTILIZATION REVIEW ORGANIZATION  
6 DESIGNATED BY THE INSURER, FAILS TO PROVIDE THE DOCUMENTS AND  
7 INFORMATION WITHIN THE TIME PERIOD SPECIFIED IN PARAGRAPH  
8 (1), THE ASSIGNED IRO MAY TERMINATE THE EXTERNAL REVIEW AND  
9 MAKE A DECISION TO REVERSE THE ADVERSE BENEFIT DETERMINATION  
10 OR FINAL ADVERSE BENEFIT DETERMINATION. WITHIN 24 HOURS UPON  
11 MAKING THE DECISION, THE IRO SHALL NOTIFY THE DEPARTMENT, THE  
12 INSURER, THE COVERED PERSON, AND, IF APPLICABLE, THE COVERED  
13 PERSON'S AUTHORIZED REPRESENTATIVE.

14 (F) REVIEW OF INFORMATION.--

15 (1) EACH CLINICAL REVIEWER SELECTED UNDER SUBSECTION (D)  
16 SHALL REVIEW ALL OF THE INFORMATION AND DOCUMENTS RECEIVED  
17 UNDER SUBSECTION (E) AND OTHER INFORMATION SUBMITTED IN  
18 WRITING BY THE COVERED PERSON OR COVERED PERSON'S AUTHORIZED  
19 REPRESENTATIVE IN RESPONSE TO THE NOTICE PROVIDED UNDER <--  
20 SUBSECTION (D) (1) (II).

21 (2) WITHIN ONE BUSINESS DAY OF RECEIPT OF INFORMATION  
22 SUBMITTED BY THE COVERED PERSON OR COVERED PERSON'S  
23 AUTHORIZED REPRESENTATIVE UNDER SUBSECTION (D) (1) (II), THE  
24 ASSIGNED IRO SHALL FORWARD THE INFORMATION TO THE INSURER.

25 (G) RECONSIDERATION BY INSURER.--

26 (1) UPON RECEIPT OF THE INFORMATION, IF ANY, REQUIRED TO  
27 BE FORWARDED UNDER SUBSECTION (F) (2), THE INSURER MAY  
28 RECONSIDER AN ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE  
29 BENEFIT DETERMINATION THAT IS THE SUBJECT OF THE EXTERNAL  
30 REVIEW.

1           (2) RECONSIDERATION BY THE INSURER OF AN ADVERSE BENEFIT  
2 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION UNDER  
3 PARAGRAPH (1) MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

4           (3) THE EXTERNAL REVIEW MAY BE TERMINATED WITHOUT AN IRO  
5 DETERMINATION ONLY IF THE INSURER DECIDES, UPON COMPLETION OF  
6 RECONSIDERATION, TO REVERSE THE ADVERSE BENEFIT DETERMINATION  
7 OR FINAL ADVERSE BENEFIT DETERMINATION AND PROVIDE COVERAGE  
8 OR PAYMENT FOR THE RECOMMENDED HEALTH CARE SERVICE THAT IS  
9 THE SUBJECT OF THE EXTERNAL REVIEW.

10           (4) WITHIN ONE BUSINESS DAY OF MAKING THE DECISION TO  
11 REVERSE THE INSURER'S ADVERSE BENEFIT DETERMINATION OR FINAL  
12 ADVERSE BENEFIT DETERMINATION, AS PROVIDED IN PARAGRAPH (3),  
13 THE INSURER SHALL NOTIFY THE DEPARTMENT, THE ASSIGNED IRO,  
14 THE COVERED PERSON, AND, IF APPLICABLE, THE COVERED PERSON'S  
15 AUTHORIZED REPRESENTATIVE, IN WRITING OF THE INSURER'S  
16 DECISION.

17           (5) THE ASSIGNED IRO SHALL TERMINATE THE EXTERNAL REVIEW  
18 UPON RECEIPT OF THE NOTICE FROM THE INSURER UNDER PARAGRAPH  
19 (4).

20 (H) CLINICAL REVIEW PROCESS.--

21           (1) EXCEPT AS PROVIDED IN PARAGRAPH (3), WITHIN 20 DAYS  
22 OF BEING SELECTED IN ACCORDANCE WITH SUBSECTION (D) TO  
23 CONDUCT THE EXTERNAL REVIEW, EACH CLINICAL REVIEWER SHALL  
24 PROVIDE AN OPINION TO THE ASSIGNED IRO REGARDING WHETHER THE  
25 RECOMMENDED OR REQUESTED HEALTH CARE SERVICE SHOULD BE  
26 COVERED.

27           (2) EXCEPT FOR AN OPINION PROVIDED UNDER PARAGRAPH (3),  
28 A CLINICAL REVIEWER'S OPINION SHALL BE IN WRITING AND INCLUDE  
29 THE FOLLOWING INFORMATION:

30           (I) A DESCRIPTION OF THE COVERED PERSON'S MEDICAL

1           CONDITION.

2           (II) A DESCRIPTION OF THE INDICATORS RELEVANT TO  
3 DETERMINING WHETHER THERE IS SUFFICIENT EVIDENCE TO  
4 DEMONSTRATE THAT:

5           (A) THE RECOMMENDED OR REQUESTED HEALTH CARE  
6 SERVICE IS MORE LIKELY THAN NOT TO BE BENEFICIAL TO  
7 THE COVERED PERSON THAN ANY AVAILABLE STANDARD HEALTH  
8 CARE SERVICE.

9           (B) THE ADVERSE RISKS OF THE RECOMMENDED OR  
10 REQUESTED HEALTH CARE SERVICE WOULD NOT BE  
11 SUBSTANTIALLY INCREASED OVER THE ADVERSE RISKS OF  
12 AVAILABLE STANDARD HEALTH CARE SERVICE.

13           (III) A DESCRIPTION AND ANALYSIS OF MEDICAL OR  
14 SCIENTIFIC EVIDENCE CONSIDERED IN REACHING THE OPINION.

15           (IV) A DESCRIPTION AND ANALYSIS OF AN EVIDENCE-BASED  
16 STANDARD.

17           (V) INFORMATION ON WHETHER THE REVIEWER'S RATIONALE  
18 FOR THE OPINION IS BASED ON SUBSECTION (I) (5) (I) OR (II).

19           (3) THE FOLLOWING SHALL APPLY:

20           (I) FOR AN EXPEDITED EXTERNAL REVIEW, A CLINICAL  
21 REVIEWER SHALL PROVIDE AN OPINION ORALLY OR IN WRITING TO  
22 THE ASSIGNED IRO AS EXPEDITIOUSLY AS THE COVERED PERSON'S  
23 MEDICAL CONDITION OR CIRCUMSTANCES REQUIRE, BUT IN NO  
24 EVENT MORE THAN FIVE CALENDAR DAYS AFTER BEING SELECTED  
25 IN ACCORDANCE WITH SUBSECTION (D).

26           (II) IF THE OPINION PROVIDED UNDER SUBPARAGRAPH (I)  
27 IS NOT IN WRITING, WITHIN 48 HOURS OF THE DATE THE  
28 OPINION WAS PROVIDED, THE CLINICAL REVIEWER SHALL PROVIDE  
29 WRITTEN CONFIRMATION OF THE OPINION TO THE ASSIGNED IRO  
30 AND INCLUDE THE INFORMATION REQUIRED UNDER PARAGRAPH (2).

1 (I) FACTORS TO BE CONSIDERED.--IN ADDITION TO THE DOCUMENTS  
2 AND INFORMATION PROVIDED UNDER SUBSECTION (A) (2) OR (E), A  
3 CLINICAL REVIEWER SELECTED UNDER SUBSECTION (D), TO THE EXTENT  
4 THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE REVIEWER  
5 CONSIDERS APPROPRIATE, SHALL CONSIDER THE FOLLOWING IN REACHING  
6 AN OPINION UNDER SUBSECTION (H):

7 (1) THE COVERED PERSON'S MEDICAL RECORDS.

8 (2) THE ATTENDING HEALTH CARE PROVIDER'S RECOMMENDATION.

9 (3) CONSULTING REPORTS FROM APPROPRIATE HEALTH CARE  
10 PROVIDERS AND OTHER DOCUMENTS SUBMITTED BY THE INSURER, THE  
11 COVERED PERSON, AND, IF APPLICABLE, THE COVERED PERSON'S  
12 AUTHORIZED REPRESENTATIVE OR TREATING PROVIDER.

13 (4) THE TERMS OF COVERAGE UNDER THE COVERED PERSON'S  
14 HEALTH INSURANCE POLICY TO ENSURE THAT THE IRO'S DECISION IS  
15 NOT CONTRARY TO THE TERMS.

16 (5) WHETHER EITHER OF THE FOLLOWING IS SATISFIED:

17 (I) THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE  
18 HAS BEEN APPROVED BY THE UNITED STATES FOOD AND DRUG  
19 ADMINISTRATION, IF APPLICABLE, FOR THE CONDITION.

20 (II) MEDICAL OR SCIENTIFIC EVIDENCE OR EVIDENCE-  
21 BASED STANDARDS DEMONSTRATE THAT:

22 (A) THE EXPECTED BENEFIT OF THE RECOMMENDED OR  
23 REQUESTED HEALTH CARE SERVICE IS MORE LIKELY THAN NOT  
24 TO BE BENEFICIAL TO THE COVERED PERSON THAN ANY  
25 AVAILABLE STANDARD HEALTH CARE SERVICE.

26 (B) THE ADVERSE RISKS OF THE RECOMMENDED OR  
27 REQUESTED HEALTH CARE SERVICE WOULD NOT BE  
28 SUBSTANTIALLY INCREASED OVER THE ADVERSE RISKS OF AN  
29 AVAILABLE STANDARD HEALTH CARE SERVICE.

30 (J) NOTICE OF DECISION.--

1           (1) WITHIN EXCEPT AS REQUIRED UNDER SECTION 2164.6(E)  
2           FOR AN EXPEDITED EXTERNAL REVIEW, WITHIN 20 DAYS OF THE DATE  
3           THE ASSIGNED IRO RECEIVES THE OPINION OF A CLINICAL REVIEWER,  
4           THE ASSIGNED IRO SHALL PROVIDE WRITTEN NOTICE OF THE ASSIGNED  
5           IRO'S DECISION TO UPHOLD OR REVERSE THE ADVERSE BENEFIT  
6           DETERMINATION TO:

7                   (I) THE COVERED PERSON.

8                   (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED  
9                   REPRESENTATIVE.

10                   (III) THE INSURER.

11                   (IV) THE DEPARTMENT.

12           (2) IF A MAJORITY OF THE CLINICAL REVIEWERS RECOMMEND  
13           THAT:

14                   (I) THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE  
15                   BE COVERED, THE IRO SHALL MAKE A DECISION TO REVERSE THE  
16                   INSURER'S ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE  
17                   BENEFIT DETERMINATION.

18                   (II) THE RECOMMENDED OR REQUESTED HEALTH CARE  
19                   SERVICE NOT BE COVERED, THE IRO SHALL MAKE A DECISION TO  
20                   UPHOLD THE INSURER'S ADVERSE BENEFIT DETERMINATION OR  
21                   FINAL ADVERSE BENEFIT DETERMINATION.

22           (3) IF THE CLINICAL REVIEWERS ARE EVENLY DIVIDED AS TO  
23           WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE  
24           SHOULD BE COVERED:

25                   (I) THE IRO SHALL OBTAIN THE OPINION OF AN  
26                   ADDITIONAL CLINICAL REVIEWER IN ORDER FOR THE IRO TO MAKE  
27                   A DECISION BASED ON THE OPINIONS OF A MAJORITY OF THE  
28                   CLINICAL REVIEWERS.

29                   (II) THE ADDITIONAL CLINICAL REVIEWER SELECTED SHALL  
30                   USE THE SAME INFORMATION TO REACH AN OPINION AS THE

1 CLINICAL REVIEWERS WHO HAVE ALREADY SUBMITTED THEIR  
2 OPINION OPINIONS.

3 (III) THE SELECTION OF THE ADDITIONAL CLINICAL  
4 REVIEWER MAY NOT EXTEND THE TIME WITHIN WHICH THE  
5 ASSIGNED IRO IS REQUIRED TO MAKE A DECISION.

6 (4) THE IRO SHALL INCLUDE THE FOLLOWING IN THE NOTICE  
7 PROVIDED UNDER PARAGRAPH (1):

8 (I) A GENERAL DESCRIPTION OF THE REASON FOR THE  
9 REQUEST FOR EXTERNAL REVIEW.

10 (II) THE WRITTEN OPINION OF EACH CLINICAL REVIEWER,  
11 INCLUDING THE RECOMMENDATION OF EACH CLINICAL REVIEWER AS  
12 TO WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE  
13 SERVICE SHOULD BE COVERED AND THE RATIONALE FOR THE  
14 REVIEWER'S RECOMMENDATION.

15 (III) THE DATE THE IRO WAS ASSIGNED BY THE  
16 DEPARTMENT TO CONDUCT THE EXTERNAL REVIEW.

17 (IV) THE DATE OF THE EXTERNAL REVIEW.

18 (V) THE DATE OF THE IRO'S DECISION.

19 (VI) THE PRINCIPAL REASON OR REASONS FOR THE IRO'S  
20 DECISION.

21 (VII) THE RATIONALE FOR THE IRO'S DECISION.

22 (5) UPON RECEIPT OF A NOTICE OF A DECISION UNDER  
23 PARAGRAPH (1) REVERSING THE ADVERSE BENEFIT DETERMINATION OR  
24 FINAL ADVERSE BENEFIT DETERMINATION, THE INSURER SHALL,  
25 WITHIN 24 HOURS, APPROVE THE COVERAGE THAT WAS THE SUBJECT OF  
26 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
27 DETERMINATION.

28 (K) ASSIGNMENT OF IRO.--THE DEPARTMENT SHALL ASSIGN, ON A  
29 RANDOM BASIS, AN APPROVED IRO AMONG THOSE QUALIFIED TO CONDUCT  
30 THE PARTICULAR EXTERNAL REVIEW BASED ON THE NATURE OF THE HEALTH

1 CARE SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT  
2 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, AND SHALL  
3 CONSIDER THE CONFLICT-OF-INTEREST CONCERNS UNDER SECTION  
4 2164.10(D).

5 SECTION 2164.8. BINDING NATURE OF EXTERNAL REVIEW DECISION.

6 (A) BINDING ON INSURER.--AN EXTERNAL REVIEW DECISION SHALL  
7 BE BINDING ON THE INSURER, EXCEPT TO THE EXTENT THE INSURER HAS  
8 OTHER REMEDIES AVAILABLE UNDER APPLICABLE STATE LAW.

9 (B) BINDING ON COVERED PERSON.--AN EXTERNAL REVIEW DECISION  
10 SHALL BE BINDING ON A COVERED PERSON, EXCEPT TO THE EXTENT THE  
11 COVERED PERSON HAS OTHER REMEDIES AVAILABLE UNDER APPLICABLE  
12 FEDERAL AND STATE LAW.

13 (C) FINALITY OF DECISION.--NEITHER THE COVERED PERSON NOR  
14 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE MAY FILE A  
15 SUBSEQUENT REQUEST FOR EXTERNAL REVIEW INVOLVING THE SAME  
16 ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
17 DETERMINATION FOR WHICH THE COVERED PERSON HAS ALREADY RECEIVED  
18 AN EXTERNAL REVIEW DECISION UNDER THIS SUBARTICLE SUBDIVISION. <--

19 SECTION 2164.9. DEPARTMENT APPROVAL OF INDEPENDENT REVIEW  
20 ORGANIZATIONS.

21 (A) GENERAL RULE.--THE DEPARTMENT MAY APPROVE AN IRO  
22 ELIGIBLE TO BE ASSIGNED TO CONDUCT EXTERNAL REVIEWS UNDER  
23 SECTION 2162 OR THIS SUBDIVISION. <--

24 (B) ELIGIBILITY REQUIREMENTS.--TO BE ELIGIBLE FOR APPROVAL  
25 BY THE DEPARTMENT UNDER THIS SECTION TO CONDUCT EXTERNAL REVIEWS  
26 UNDER SECTION 2162 OR THIS SUBDIVISION, AN IRO MUST: <--

27 (1) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, BE  
28 ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING  
29 ENTITY THAT THE DEPARTMENT HAS DETERMINED TO POSSESS IRO  
30 ACCREDITATION STANDARDS THAT ARE EQUIVALENT TO OR EXCEED THE

1 MINIMUM QUALIFICATIONS FOR THE IROS ESTABLISHED UNDER SECTION  
2 ~~2611.1~~ 2164.10. <--

3 (2) SUBMIT AN APPLICATION FOR APPROVAL IN ACCORDANCE  
4 WITH SUBSECTION (D).

5 (3) IDENTIFY THE IRO'S PROPOSED FEES FOR EXTERNAL  
6 REVIEWS.

7 (C) FORM OF APPLICATION.--THE DEPARTMENT SHALL DEVELOP AN  
8 APPLICATION FORM FOR INITIALLY APPROVING AND FOR RENEWING THE  
9 APPROVAL OF IROS TO CONDUCT EXTERNAL REVIEWS.

10 (D) CONSIDERATION OF APPLICATION.--

11 (1) AN IRO SEEKING APPROVAL TO CONDUCT EXTERNAL REVIEWS  
12 UNDER SECTION 2162 OR THIS SUBDIVISION SHALL SUBMIT THE <--  
13 APPLICATION FORM AND INCLUDE WITH THE FORM ALL DOCUMENTATION  
14 AND INFORMATION NECESSARY FOR THE DEPARTMENT TO DETERMINE  
15 WHETHER THE IRO SATISFIES THE MINIMUM QUALIFICATIONS  
16 ESTABLISHED UNDER SECTION 2164.10.

17 (2) THE DEPARTMENT MAY APPROVE AN IRO THAT IS NOT  
18 ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING  
19 ENTITY IF THERE ARE NO ACCEPTABLE NATIONALLY RECOGNIZED  
20 PRIVATE ACCREDITING ENTITIES PROVIDING IRO ACCREDITATION.

21 (3) THE DEPARTMENT MAY CHARGE THE IRO AN APPLICATION FEE  
22 TO BE SUBMITTED WITH AN APPLICATION FOR APPROVAL OR FOR  
23 RENEWAL.

24 (4) THE DEPARTMENT MAY DECLINE TO CERTIFY AN IRO IF THE  
25 IRO'S PROPOSED FEES FOR EXTERNAL REVIEWS ARE DETERMINED BY  
26 THE DEPARTMENT TO BE UNREASONABLE.

27 (E) DURATION OF APPROVAL.--

28 (1) AN APPROVAL SHALL BE VALID FOR TWO YEARS UNLESS THE  
29 DEPARTMENT DETERMINES BEFORE THE APPROVAL EXPIRES THAT THE  
30 IRO NO LONGER SATISFIES THE MINIMUM QUALIFICATIONS



1 ESTABLISHED UNDER SECTION 2164.10.

2 (2) IF THE DEPARTMENT DETERMINES THAT AN IRO IS NO  
3 LONGER ACCREDITED OR NO LONGER SATISFIES THE MINIMUM  
4 REQUIREMENTS ESTABLISHED UNDER SECTION 2164.10, THE  
5 DEPARTMENT MAY TERMINATE THE APPROVAL OF THE IRO AND REMOVE  
6 THE IRO FROM THE LIST OF IROS APPROVED TO CONDUCT EXTERNAL  
7 REVIEWS UNDER THIS SUBDIVISION.

8 (F) LIST OF APPROVED IROS.--THE DEPARTMENT SHALL MAINTAIN  
9 AND PERIODICALLY ANNUALLY UPDATE A LIST OF APPROVED IROS AND <--  
10 THEIR FEES. THE DEPARTMENT SHALL PERIODICALLY TRANSMIT NOTICE A  
11 LIST OF APPROVED IROS TO THE LEGISLATIVE REFERENCE BUREAU FOR  
12 PUBLICATION IN THE PENNSYLVANIA BULLETIN.

13 (G) NO PROHIBITION.--NOTHING IN THIS SECTION OR IN SECTION  
14 2164.10 SHALL PROHIBIT AN ENTITY CERTIFIED AS A UTILIZATION  
15 REVIEW ENTITY FROM BEING APPROVED AS AN IRO.  
16 SECTION 2164.10. MINIMUM QUALIFICATIONS FOR INDEPENDENT REVIEW  
17 ORGANIZATIONS.

18 (A) REQUIREMENTS FOR DEPARTMENT APPROVAL.--TO BE APPROVED  
19 UNDER SECTION 2164.9 TO CONDUCT EXTERNAL REVIEWS AND EXTERNAL  
20 GRIEVANCES, AN IRO MUST ESTABLISH AND MAINTAIN WRITTEN POLICIES  
21 AND PROCEDURES THAT GOVERN ALL ASPECTS OF BOTH THE STANDARD AND  
22 EXPEDITED ADVERSE BENEFIT DETERMINATION EXTERNAL REVIEW AND  
23 EXTERNAL GRIEVANCE REVIEW REQUIRED BY SECTIONS 2162, 2162.6 AND <--  
24 2162.7 SECTION 2162 AND THIS SUBDIVISION THAT INCLUDE, AT A <--  
25 MINIMUM:

26 (1) A QUALITY ASSURANCE MECHANISM IN PLACE THAT ENSURES:

27 (I) THAT AN EXTERNAL REVIEW IS CONDUCTED WITHIN THE  
28 SPECIFIED TIME PERIOD AND THAT REQUIRED NOTICES ARE  
29 PROVIDED IN A TIMELY MANNER.

30 (II) THE SELECTION OF QUALIFIED AND IMPARTIAL

1 CLINICAL REVIEWERS TO CONDUCT EXTERNAL REVIEW ON BEHALF  
2 OF THE IRO, AND SUITABLE MATCHING OF REVIEWERS TO  
3 SPECIFIC CASES.

4 (III) THAT AN IRO EMPLOYS OR CONTRACTS WITH AN  
5 ADEQUATE NUMBER OF CLINICAL REVIEWERS TO SUITABLY MATCH  
6 REVIEWERS TO SPECIFIC CASES.

7 (IV) THE CONFIDENTIALITY OF MEDICAL AND TREATMENT  
8 RECORDS AND CLINICAL REVIEW CRITERIA.

9 (V) THAT A PERSON EMPLOYED BY OR UNDER CONTRACT WITH  
10 THE IRO ADHERES TO THE REQUIREMENTS OF THIS SUBDIVISION <--  
11 ARTICLE. <--

12 (VI) THAT THE IRO AND ITS ASSIGNED CLINICAL  
13 REVIEWERS ARE UNBIASED IN THE CONDUCT OF AN EXTERNAL  
14 REVIEW.

15 (2) A TOLL-FREE TELEPHONE SERVICE TO RECEIVE INFORMATION  
16 24 HOURS PER DAY, 7 DAYS PER WEEK, RELATED TO EXTERNAL  
17 REVIEWS, THAT IS CAPABLE OF ACCEPTING, RECORDING OR PROVIDING  
18 APPROPRIATE INSTRUCTION TO INCOMING TELEPHONE CALLERS DURING  
19 OTHER-THAN-NORMAL BUSINESS HOURS.

20 (3) AN AGREEMENT TO MAINTAIN AND PROVIDE TO THE  
21 DEPARTMENT THE INFORMATION DESCRIBED IN SECTION 2164.12.

22 (B) QUALIFICATIONS OF CLINICAL REVIEWER.--A CLINICAL  
23 REVIEWER ASSIGNED BY AN IRO TO CONDUCT EXTERNAL REVIEW MUST BE A  
24 PHYSICIAN OR OTHER APPROPRIATE HEALTH CARE PROVIDER WHO MEETS  
25 THE FOLLOWING MINIMUM QUALIFICATIONS:

26 (1) HAS EXPERTISE IN THE TREATMENT OF THE COVERED  
27 PERSON'S OR ENROLLEE'S MEDICAL CONDITION THAT IS THE SUBJECT  
28 OF THE EXTERNAL REVIEW.

29 (2) IS KNOWLEDGEABLE ABOUT THE RECOMMENDED HEALTH CARE  
30 SERVICE THROUGH RECENT OR CURRENT ACTUAL CLINICAL EXPERIENCE

1 TREATING PATIENTS WITH THE SAME OR SIMILAR MEDICAL CONDITION  
2 OF THE COVERED PERSON OR ENROLLEE.

3 (3) HOLDS A NONRESTRICTED LICENSE IN A STATE OR  
4 COMMONWEALTH OF THE UNITED STATES AND, FOR A PHYSICIAN, A  
5 CURRENT CERTIFICATION FROM A RECOGNIZED AMERICAN MEDICAL  
6 SPECIALTY BOARD IN THE AREA OR AREAS OF MEDICINE APPROPRIATE  
7 TO THE SUBJECT OF THE EXTERNAL REVIEW.

8 (4) HAS NO HISTORY OF DISCIPLINARY ACTIONS OR SANCTIONS,  
9 INCLUDING LOSS OF STAFF PRIVILEGES OR PARTICIPATION  
10 RESTRICTIONS, THAT HAVE BEEN TAKEN OR ARE PENDING BY A  
11 HOSPITAL, GOVERNMENTAL AGENCY OR UNIT OR REGULATORY BODY THAT  
12 RAISE A SUBSTANTIAL QUESTION AS TO THE CLINICAL REVIEWER'S  
13 PHYSICAL, MENTAL OR PROFESSIONAL COMPETENCE OR MORAL  
14 CHARACTER.

15 (C) PROHIBITED RELATIONSHIPS.--IN ADDITION TO THE  
16 REQUIREMENTS UNDER SUBSECTION (A), AN IRO MAY NOT OWN OR  
17 CONTROL, BE A SUBSIDIARY OF OR IN ANY WAY BE OWNED OR CONTROLLED  
18 BY OR EXERCISE CONTROL WITH AN INSURER OR MA OR CHIP MANAGED  
19 CARE PLAN, A NATIONAL, STATE OR LOCAL TRADE ASSOCIATION OF  
20 INSURERS OR MA OR CHIP MANAGED CARE PLANS, OR A NATIONAL, STATE <--  
21 OR LOCAL TRADE ASSOCIATION OF HEALTH CARE PROVIDERS.

22 (D) CONFLICTS OF INTEREST.--

23 (1) IN ADDITION TO THE REQUIREMENTS UNDER THIS SECTION,  
24 TO BE APPROVED UNDER SECTIONS ~~2162, 2162.6 OR 2162.7~~ SECTION <--  
25 2164.9 TO CONDUCT AN EXTERNAL REVIEW OF A SPECIFIED CASE,  
26 NEITHER THE IRO SELECTED TO CONDUCT THE EXTERNAL REVIEW NOR A  
27 CLINICAL REVIEWER ASSIGNED BY THE IRO TO CONDUCT THE EXTERNAL  
28 REVIEW MAY HAVE A MATERIAL PROFESSIONAL, FAMILIAL OR  
29 FINANCIAL CONFLICT OF INTEREST WITH ANY OF THE FOLLOWING:

30 (I) THE INSURER OR MA OR CHIP MANAGED CARE PLAN THAT

1 IS THE SUBJECT OF THE EXTERNAL REVIEW.

2 (II) THE COVERED PERSON OR ENROLLEE WHOSE TREATMENT  
3 IS THE SUBJECT OF THE EXTERNAL REVIEW OR THE COVERED  
4 PERSON'S OR ENROLLEE'S AUTHORIZED REPRESENTATIVE.

5 (III) AN OFFICER, DIRECTOR OR MANAGEMENT EMPLOYEE OF  
6 THE INSURER OR MA OR CHIP MANAGED CARE PLAN THAT IS THE  
7 SUBJECT OF THE EXTERNAL REVIEW.

8 (IV) THE HEALTH CARE PROVIDER, THE HEALTH CARE  
9 PROVIDER'S MEDICAL GROUP OR INDEPENDENT PRACTICE  
10 ASSOCIATION RECOMMENDING THE HEALTH CARE SERVICE THAT IS  
11 THE SUBJECT OF THE EXTERNAL REVIEW.

12 (V) THE FACILITY AT WHICH THE RECOMMENDED HEALTH  
13 CARE SERVICE WOULD BE PROVIDED.

14 (VI) THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL  
15 DRUG, DEVICE, PROCEDURE OR OTHER THERAPY BEING  
16 RECOMMENDED FOR THE COVERED PERSON OR ENROLLEE WHOSE  
17 TREATMENT IS THE SUBJECT OF THE EXTERNAL REVIEW.

18 (2) IN DETERMINING WHETHER AN IRO OR CLINICAL REVIEWER  
19 OF THE IRO HAS A MATERIAL PROFESSIONAL, FAMILIAL OR FINANCIAL  
20 CONFLICT OF INTEREST FOR PURPOSES OF PARAGRAPH (1), THE  
21 DEPARTMENT SHALL TAKE INTO CONSIDERATION SITUATIONS WHERE AN  
22 APPARENT CONFLICT OF INTEREST UNDER PARAGRAPH (1) IS NOT  
23 MATERIAL.

24 (E) ACCREDITATION.--

25 (1) AN IRO THAT IS ACCREDITED BY A NATIONALLY RECOGNIZED  
26 PRIVATE ACCREDITING ENTITY THAT POSSESSES INDEPENDENT REVIEW  
27 ACCREDITATION STANDARDS THAT THE DEPARTMENT HAS DETERMINED  
28 ARE EQUIVALENT TO OR EXCEED THE MINIMUM QUALIFICATIONS OF  
29 THIS SECTION SHALL BE PRESUMED TO BE IN COMPLIANCE WITH THIS  
30 SECTION TO BE ELIGIBLE FOR APPROVAL UNDER SECTION 2164.9.

1           (2) THE DEPARTMENT SHALL INITIALLY AND PERIODICALLY  
2 REVIEW THE IRO ACCREDITATION STANDARDS OF A NATIONALLY  
3 RECOGNIZED PRIVATE ACCREDITING ENTITY TO DETERMINE WHETHER  
4 THE ENTITY'S STANDARDS ARE, AND CONTINUE TO BE, EQUIVALENT TO  
5 OR EXCEEDING THE MINIMUM QUALIFICATIONS ESTABLISHED UNDER  
6 THIS SECTION. THE DEPARTMENT MAY ACCEPT A REVIEW CONDUCTED BY  
7 THE NAIC FOR THE PURPOSES OF THE DETERMINATION UNDER THIS  
8 PARAGRAPH.

9           (3) UPON REQUEST, A NATIONALLY RECOGNIZED PRIVATE  
10 ACCREDITING ENTITY SHALL MAKE ITS CURRENT IRO ACCREDITATION  
11 STANDARDS AVAILABLE TO THE DEPARTMENT OR THE NAIC IN ORDER  
12 FOR THE DEPARTMENT TO DETERMINE IF THE ENTITY'S STANDARDS  
13 EXCEED OR ARE EQUIVALENT TO THE MINIMUM QUALIFICATIONS  
14 ESTABLISHED UNDER THIS SECTION. THE DEPARTMENT MAY EXCLUDE A  
15 PRIVATE ACCREDITING ENTITY THAT IS NOT REVIEWED BY THE NAIC.  
16 SECTION 2164.11. HOLD HARMLESS FOR INDEPENDENT REVIEW  
17 ORGANIZATIONS.

18           NO IRO, CLINICAL REVIEWER WORKING ON BEHALF OF AN IRO OR AN  
19 EMPLOYEE, AGENT OR CONTRACTOR OF AN IRO MAY BE HELD LIABLE FOR  
20 DAMAGES TO A PERSON FOR AN OPINION RENDERED, OR ACT OR OMISSION  
21 PERFORMED, WITHIN THE SCOPE OF THE ORGANIZATION'S OR PERSON'S  
22 DUTIES UNDER THE LAW DURING OR UPON COMPLETION OF AN EXTERNAL  
23 REVIEW CONDUCTED UNDER SECTION 2162 OR THIS SUBDIVISION, UNLESS <--  
24 THE OPINION WAS RENDERED, OR ACT OR OMISSION PERFORMED, IN BAD  
25 FAITH OR INVOLVED GROSS NEGLIGENCE.

26 SECTION 2164.12. EXTERNAL REVIEW REPORTING REQUIREMENTS.

27           (A) RECORDKEEPING BY IROS.--

28           (1) AN IRO ASSIGNED UNDER SECTION 2162 OR THIS <--  
29 SUBDIVISION TO CONDUCT AN EXTERNAL REVIEW SHALL MAINTAIN  
30 WRITTEN RECORDS IN THE AGGREGATE FOR THE ENTIRE COMMONWEALTH

1 AND FOR EACH INSURER OR MA OR CHIP MANAGED CARE PLAN, ON ALL  
2 REQUESTS FOR WHICH THE IRO CONDUCTED AN EXTERNAL REVIEW  
3 DURING A CALENDAR YEAR.

4 (2) AN IRO REQUIRED TO MAINTAIN WRITTEN RECORDS UNDER  
5 PARAGRAPH (1) ON ALL REQUESTS FOR EXTERNAL REVIEW FOR WHICH  
6 THE IRO WAS ASSIGNED TO CONDUCT AN EXTERNAL REVIEW SHALL  
7 SUBMIT TO THE DEPARTMENT, UPON REQUEST, A REPORT IN THE  
8 FORMAT SPECIFIED BY THE DEPARTMENT.

9 (3) THE REPORT SHALL INCLUDE IN THE AGGREGATE, FOR THE  
10 ENTIRE COMMONWEALTH AND FOR EACH INSURER OR MA OR CHIP  
11 MANAGED CARE PLAN:

12 (I) THE TOTAL NUMBER OF REQUESTS FOR EXTERNAL  
13 REVIEW.

14 (II) THE NUMBER OF REQUESTS FOR EXTERNAL REVIEW  
15 RESOLVE AND, OF THOSE RESOLVED, THE NUMBER RESOLVED  
16 UPHOLDING THE GRIEVANCE DECISION, ADVERSE BENEFIT <--  
17 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION AND  
18 THE NUMBER RESOLVED REVERSING THE GRIEVANCE DECISION, <--  
19 ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT  
20 DETERMINATION.

21 (III) THE AVERAGE LENGTH OF TIME FOR EXTERNAL REVIEW  
22 REQUEST RESOLUTION.

23 (IV) A SUMMARY OF THE TYPES OF COVERAGES OR CASES  
24 FOR WHICH AN EXTERNAL REVIEW WAS SOUGHT, PROVIDED IN A  
25 FORMAT SPECIFIED BY THE DEPARTMENT.

26 (V) THE NUMBER OF EXTERNAL REVIEWS UNDER SECTIONS  
27 2164.5 AND 2164.7 THAT WERE TERMINATED AS THE RESULT OF A  
28 RECONSIDERATION BY THE INSURER OF THE ADVERSE BENEFIT  
29 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION  
30 AFTER THE RECEIPT OF ADDITIONAL INFORMATION FROM THE

1 COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED  
2 REPRESENTATIVE.

3 (VI) OTHER INFORMATION THE DEPARTMENT MAY REQUEST OR  
4 REQUIRE.

5 (4) THE IRO SHALL RETAIN THE WRITTEN RECORDS REQUIRED  
6 UNDER THIS SUBSECTION FOR AT LEAST THREE YEARS.

7 (B) RECORDKEEPING BY INSURERS.--

8 (1) AN INSURER SHALL MAINTAIN WRITTEN RECORDS IN THE  
9 AGGREGATE, FOR THE ENTIRE COMMONWEALTH, FOR EACH TYPE OF  
10 HEALTH INSURANCE POLICY OFFERED BY THE INSURER, ON ALL  
11 REQUESTS FOR EXTERNAL REVIEW AS TO WHICH THE INSURER RECEIVES  
12 NOTICE FROM THE DEPARTMENT UNDER THIS ~~SUBARTICLE~~ SUBDIVISION. <--

13 (2) AN INSURER REQUIRED TO MAINTAIN WRITTEN RECORDS  
14 UNDER PARAGRAPH (1) SHALL SUBMIT TO THE DEPARTMENT, UPON  
15 REQUEST, A REPORT IN THE FORMAT SPECIFIED BY THE DEPARTMENT.

16 (3) THE REPORT SHALL INCLUDE IN THE AGGREGATE, FOR THE  
17 ENTIRE COMMONWEALTH AND FOR EACH TYPE OF HEALTH INSURANCE  
18 POLICY OFFERED BY THE INSURER:

19 (I) THE TOTAL NUMBER OF REQUESTS FOR EXTERNAL  
20 REVIEW.

21 (II) OF THE TOTAL NUMBER OF REQUESTS FOR EXTERNAL  
22 REVIEW REPORTED UNDER SUBPARAGRAPH (I), THE NUMBER OF  
23 REQUESTS DETERMINED ELIGIBLE FOR EXTERNAL REVIEW.

24 (III) OTHER INFORMATION THE DEPARTMENT MAY REQUEST  
25 OR REQUIRE.

26 (4) THE INSURER SHALL RETAIN THE WRITTEN RECORDS  
27 REQUIRED UNDER THIS SUBSECTION FOR AT LEAST THREE YEARS.

28 SECTION 2164.13. FUNDING OF EXTERNAL REVIEW.

29 (A) COST.--THE INSURER AGAINST WHICH A REQUEST FOR STANDARD  
30 EXTERNAL REVIEW OR EXPEDITED EXTERNAL REVIEW UNDER SECTION

1 2164.5, 2164.6 OR 2164.7 IS FILED SHALL PAY THE COST OF THE IRO  
2 TO CONDUCT THE EXTERNAL REVIEW.

3 (B) FEES.--THE FEES CHARGED BY AN IRO SHALL BE REASONABLE  
4 AND CUSTOMARY. THE DEPARTMENT SHALL ANNUALLY TRANSMIT NOTICE OF  
5 THE FEES FOR THE TYPES OF ADVERSE BENEFIT DETERMINATIONS UNDER  
6 REVIEW TO THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION IN  
7 THE PENNSYLVANIA BULLETIN.

8 (C) NO FEE.--A COVERED PERSON OR THE COVERED PERSON'S  
9 AUTHORIZED REPRESENTATIVE MAY NOT BE CHARGED A FEE IN ORDER TO  
10 FILE A REQUEST FOR EXTERNAL REVIEW.

11 SECTION 2164.14. AVAILABILITY OF FORMS.

12 (A) GENERAL RULE.--THE DEPARTMENT SHALL MAKE AVAILABLE, IN  
13 AN ELECTRONIC FORMAT AND, UPON REQUEST, IN PRINT FORMAT, ANY  
14 APPLICABLE FORMS ADOPTED BY THE DEPARTMENT RELATED TO AN ADVERSE  
15 BENEFIT DETERMINATION REQUEST, NOTICE OF INITIAL DETERMINATION  
16 BY INSURER, HEALTH CARE PROVIDER CERTIFICATION FOR EXPEDITED  
17 REVIEW, INSURER ANNUAL REPORT, IRO INTERNAL REPORT AND OTHER  
18 FORMS SPECIFIED BY THIS SUBDIVISION.

19 (B) LOCATION OF FORMS.--FORMS DESCRIBED IN SUBSECTION (A)  
20 SHALL BE POSTED ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE INTERNET  
21 WEBSITE.

22 (C) AMENDMENT AND REVISION.--IF FORMS DESCRIBED IN  
23 SUBSECTION (A) ARE AMENDED OR REVISED, THE DEPARTMENT SHALL  
24 TRANSMIT NOTICE OF THE CHANGES TO THE LEGISLATIVE REFERENCE  
25 BUREAU FOR PUBLICATION IN THE PENNSYLVANIA BULLETIN.

26 SECTION 8. SECTION 2166, SUBDIVISION (K) HEADING OF ARTICLE  
27 XXI AND SECTIONS 2171, ~~2181~~ AND ~~2182~~ AND 2181 OF THE ACT ARE <--  
28 AMENDED TO READ:

29 SECTION 2166. PROMPT PAYMENT OF CLAIMS.-- [(A) ~~†A LICENSED~~] <--  
30 ~~AN~~ INSURER OR ~~†A~~ MA OR CHIP MANAGED CARE PLAN SHALL PAY A CLEAN <--



1 CLAIM SUBMITTED BY A HEALTH CARE PROVIDER ~~OR COVERED PERSON~~ <--  
2 WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF THE CLEAN CLAIM.

3 (B) IF ~~{A LICENSED}~~ AN INSURER OR ~~{A} MA OR CHIP~~ MANAGED <--  
4 CARE PLAN FAILS TO REMIT THE PAYMENT AS PROVIDED UNDER  
5 SUBSECTION (A), INTEREST AT TEN PER CENTUM (10%) PER ANNUM SHALL  
6 BE ADDED TO THE AMOUNT OWED ON THE CLEAN CLAIM. INTEREST SHALL  
7 BE CALCULATED BEGINNING THE DAY AFTER THE REQUIRED PAYMENT DATE  
8 AND ENDING ON THE DATE THE CLAIM IS PAID. THE ~~{LICENSED}~~ INSURER <--  
9 OR ~~MA OR CHIP~~ MANAGED CARE PLAN SHALL NOT BE REQUIRED TO PAY ANY <--  
10 INTEREST CALCULATED TO BE LESS THAN TWO (\$2) DOLLARS.] (A) AN <--  
11 INSURER SHALL PAY A CLEAN CLAIM SUBMITTED BY A HEALTH CARE  
12 PROVIDER OR COVERED PERSON WITHIN FORTY-FIVE (45) DAYS OF  
13 RECEIPT OF THE CLEAN CLAIM.

14 (A.1) AN MA OR CHIP MANAGED CARE PLAN SHALL PAY A CLEAN  
15 CLAIM SUBMITTED BY A HEALTH CARE PROVIDER WITHIN FORTY-FIVE (45)  
16 DAYS OF RECEIPT OF THE CLEAN CLAIM.

17 (B) IF AN INSURER FAILS TO REMIT THE PAYMENT AS PROVIDED  
18 UNDER SUBSECTION (A), INTEREST AT TEN PER CENTUM (10%) PER ANNUM  
19 SHALL BE ADDED TO THE AMOUNT OWED ON THE CLEAN CLAIM. INTEREST  
20 SHALL BE CALCULATED BEGINNING THE DAY AFTER THE REQUIRED PAYMENT  
21 DATE AND ENDING ON THE DATE THE CLAIM IS PAID. THE INSURER SHALL  
22 NOT BE REQUIRED TO PAY ANY INTEREST CALCULATED TO BE LESS THAN  
23 TWO (\$2) DOLLARS.

24 (K) [HEALTH CARE PROVIDER AND MANAGED CARE PLAN  
25 PROTECTION] CONSCIENCE PROTECTION.  
26 SECTION 2171. [HEALTH CARE PROVIDER AND MANAGED CARE PLAN]  
27 CONSCIENCE PROTECTION.-- (A) [A] AN INSURER OR MA OR CHIP  
28 MANAGED CARE PLAN SHALL NOT EXCLUDE, DISCRIMINATE AGAINST OR  
29 PENALIZE ANY HEALTH CARE PROVIDER FOR ITS REFUSAL TO ALLOW,  
30 PERFORM, PARTICIPATE IN OR REFER FOR HEALTH CARE SERVICES WHEN

1 THE REFUSAL OF THE HEALTH CARE PROVIDER IS BASED ON MORAL OR  
2 RELIGIOUS GROUNDS AND THAT PROVIDER MAKES ADEQUATE INFORMATION  
3 AVAILABLE TO [ENROLLEES] COVERED PERSONS OR ENROLLEES OR, IF <--  
4 APPLICABLE, PROSPECTIVE [ENROLLEES] COVERED PERSONS OR <--  
5 ENROLLEES.

6 (B) NO PUBLIC INSTITUTION, PUBLIC OFFICIAL OR PUBLIC AGENCY  
7 MAY TAKE DISCIPLINARY ACTION AGAINST, DENY LICENSURE OR  
8 CERTIFICATION OR PENALIZE ANY PERSON, ASSOCIATION OR CORPORATION  
9 ATTEMPTING TO ESTABLISH A [PLAN] HEALTH CARE COVERAGE ARRANGEMENT  
10 OR OPERATING, EXPANDING OR IMPROVING AN EXISTING INSURER OR MA  
11 OR CHIP MANAGED CARE PLAN BECAUSE THE PERSON, ASSOCIATION OR  
12 CORPORATION REFUSES TO PROVIDE ANY PARTICULAR FORM OF HEALTH  
13 CARE SERVICES OR OTHER SERVICES OR SUPPLIES COVERED BY OTHER  
14 INSURERS OR MA OR CHIP MANAGED CARE PLANS WHEN THE REFUSAL IS  
15 BASED ON MORAL OR RELIGIOUS GROUNDS.

16 SECTION 2181. DEPARTMENTAL POWERS AND DUTIES.-- (A) [THE  
17 DEPARTMENT SHALL REQUIRE THAT RECORDS] RECORDS AND DOCUMENTS  
18 SUBMITTED TO [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN OR  
19 UTILIZATION REVIEW ENTITY AS PART OF ANY COMPLAINT [OR],  
20 GRIEVANCE, INTERNAL APPEALS OR ADVERSE BENEFIT DETERMINATION  
21 SHALL BE MADE AVAILABLE TO THE DEPARTMENT, UPON REQUEST,  
22 NOTWITHSTANDING SECTION 2181.1, MAY BE USED FOR PURPOSES OF <--  
23 ENFORCEMENT OR COMPLIANCE WITH THIS ARTICLE.

24 (B) THE DEPARTMENT SHALL COMPILE AGGREGATE DATA RECEIVED <--  
25 FROM [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN ON AN ANNUAL  
26 BASIS REGARDING THE NUMBER, TYPE AND DISPOSITION OF COMPLAINTS  
27 [AND], GRIEVANCES, INTERNAL APPEALS AND ADVERSE BENEFITS  
28 DETERMINATIONS FILED WITH [A] AN INSURER OR MA OR CHIP MANAGED  
29 CARE PLAN UNDER THIS ARTICLE.

30 (C) THE DEPARTMENT SHALL ISSUE GUIDELINES IDENTIFYING THOSE

1 PROVISIONS OF THIS ARTICLE THAT EXCEED OR ARE NOT INCLUDED IN  
2 THE "STANDARDS FOR THE ACCREDITATION OF MANAGED CARE  
3 ORGANIZATIONS" PUBLISHED BY THE NATIONAL COMMITTEE FOR QUALITY  
4 ASSURANCE. THESE GUIDELINES SHALL BE PUBLISHED IN THE  
5 PENNSYLVANIA BULLETIN AND UPDATED AS NECESSARY. COPIES OF THE  
6 GUIDELINES SHALL BE MADE AVAILABLE TO INSURERS, MA OR CHIP  
7 MANAGED CARE PLANS, HEALTH CARE PROVIDERS AND COVERED PERSONS  
8 AND ENROLLEES UPON REQUEST.

9 (D) THE DEPARTMENT [AND THE INSURANCE DEPARTMENT] SHALL  
10 ENSURE COMPLIANCE WITH THIS ARTICLE. THE [APPROPRIATE]  
11 DEPARTMENT [SHALL] MAY INVESTIGATE POTENTIAL VIOLATIONS OF THE  
12 ARTICLE BASED UPON INFORMATION RECEIVED FROM COVERED PERSONS,  
13 ENROLLEES, HEALTH CARE PROVIDERS AND OTHER SOURCES [IN ORDER TO  
14 ENSURE COMPLIANCE WITH THIS ARTICLE].

15 [(E) THE DEPARTMENT AND THE INSURANCE DEPARTMENT SHALL  
16 PROMULGATE SUCH REGULATIONS AS MAY BE NECESSARY TO CARRY OUT THE  
17 PROVISIONS OF THIS ARTICLE.]

18 (F) THE DEPARTMENT [IN COOPERATION WITH THE INSURANCE  
19 DEPARTMENT] SHALL SUBMIT AN ANNUAL REPORT TO [THE GENERAL <--  
20 ASSEMBLY] THE CHAIRPERSON AND MINORITY CHAIRPERSON OF THE <--  
21 BANKING AND INSURANCE COMMITTEE OF THE SENATE AND THE  
22 CHAIRPERSON AND MINORITY CHAIRPERSON OF THE INSURANCE COMMITTEE  
23 OF THE HOUSE OF REPRESENTATIVES REGARDING THE IMPLEMENTATION,  
24 OPERATION AND ENFORCEMENT OF THIS ARTICLE [.] , INCLUDING THE <--  
25 AGGREGATE DATA THE DEPARTMENT HAS COMPILED UNDER SUBSECTION (B).

26 SECTION 8.1. THE ACT IS AMENDED BY ADDING A SECTION TO READ:  
27 SECTION 2181.1. CONFIDENTIALITY.-- (A) ALL RECORDS,  
28 DOCUMENTS, DATA, MATERIALS AND COPIES OF RECORDS, DOCUMENTS,  
29 DATA AND MATERIALS IN THE POSSESSION OR CONTROL OF THE  
30 DEPARTMENT THAT ARE PRODUCED BY, OBTAINED BY OR DISCLOSED TO THE

1 DEPARTMENT UNDER SECTION 2181 SHALL BE PRIVILEGED AND:

2 (1) SHALL NOT BE SUBJECT TO DISCOVERY OR ADMISSIBLE IN  
3 EVIDENCE IN A PRIVATE CIVIL ACTION;

4 (2) SHALL NOT BE SUBJECT TO SUBPOENA;

5 (3) SHALL BE EXEMPT FROM ACCESS UNDER THE ACT OF FEBRUARY  
6 14, 2008 (P.L.6, NO.3), KNOWN AS THE "RIGHT-TO-KNOW LAW"; AND

7 (4) SHALL NOT BE MADE PUBLIC BY THE DEPARTMENT OR ANY OTHER  
8 PERSON, EXCEPT TO THE REGULATORY OR LAW ENFORCEMENT OFFICIALS OF  
9 OTHER JURISDICTIONS, WITHOUT THE PRIOR WRITTEN CONSENT OF THE  
10 INSURER OR THE MA OR CHIP MANAGED CARE PLAN TO WHICH THE  
11 RECORDS, DOCUMENTS, DATA OR MATERIALS PERTAIN.

12 (B) THE DEPARTMENT OR ANY OTHER PERSON THAT RECEIVES  
13 RECORDS, DOCUMENTS, DATA, MATERIALS AND COPIES OF RECORDS,  
14 DOCUMENTS, DATA AND MATERIALS WHILE ACTING UNDER THE AUTHORITY  
15 OF THE DEPARTMENT OR WITH WHOM THE RECORDS, DOCUMENTS, DATA,  
16 MATERIALS AND COPIES OF RECORDS, DOCUMENTS, DATA AND MATERIALS  
17 ARE SHARED UNDER SECTION 2181 MAY NOT BE PERMITTED OR REQUIRED  
18 TO TESTIFY IN A PRIVATE CIVIL ACTION CONCERNING THE RECORDS,  
19 DOCUMENTS, DATA, MATERIALS AND COPIES OF RECORDS, DOCUMENTS,  
20 DATA AND MATERIALS.

21 (C) THE DEPARTMENT MAY AGGREGATE THE DATA IT RECEIVES  
22 THROUGH THE RECORDS, DOCUMENTS, DATA, MATERIALS AND COPIES OF  
23 RECORDS, DOCUMENTS, DATA AND MATERIALS DESCRIBED IN SUBSECTIONS  
24 (A) AND (B) AND RELEASE THE AGGREGATED DATA FOR THE PURPOSE OF  
25 COMPLYING WITH SECTION 2181(B). THE AGGREGATED DATA SHALL NOT  
26 INCLUDE ANY INFORMATION THAT COULD REVEAL THE IDENTITY OF  
27 COVERED PERSONS, ENROLLEES, HEALTH CARE PROVIDERS, INSURERS OR  
28 MA OR CHIP MANAGED CARE PLANS.

29 SECTION 8.2. SECTION 2182 OF THE ACT IS AMENDED TO READ:

30 SECTION 2182. PENALTIES AND SANCTIONS.--(A) THE DEPARTMENT

1 [OR THE INSURANCE DEPARTMENT, AS APPROPRIATE,] MAY IMPOSE A  
2 CIVIL PENALTY OF UP TO FIVE THOUSAND (\$5,000) DOLLARS FOR A  
3 VIOLATION OF THIS ARTICLE.

4 (B) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL BE  
5 SUBJECT TO THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS  
6 THE "UNFAIR INSURANCE PRACTICES ACT."

7 (C) THE DEPARTMENT [OR THE INSURANCE DEPARTMENT] MAY  
8 MAINTAIN AN ACTION IN THE NAME OF THE COMMONWEALTH FOR AN  
9 INJUNCTION TO PROHIBIT ANY ACTIVITY WHICH VIOLATES THE  
10 PROVISIONS OF THIS ARTICLE.

11 (D) THE DEPARTMENT MAY ISSUE AN ORDER TEMPORARILY  
12 PROHIBITING [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN WHICH  
13 VIOLATES THIS ARTICLE FROM ENROLLING NEW [MEMBERS] COVERED  
14 PERSONS OR ENROLLEES.

15 (E) THE DEPARTMENT MAY REQUIRE [A] AN INSURER OR MA OR CHIP  
16 MANAGED CARE PLAN TO DEVELOP AND ADHERE TO A PLAN OF CORRECTION  
17 APPROVED BY THE DEPARTMENT. THE DEPARTMENT SHALL MONITOR  
18 COMPLIANCE WITH THE PLAN OF CORRECTION. THE PLAN OF CORRECTION  
19 SHALL BE AVAILABLE TO COVERED PERSONS OR ENROLLEES OF THE  
20 INSURER OR MA OR CHIP MANAGED CARE PLAN UPON REQUEST.

21 [(F) IN NO EVENT SHALL THE DEPARTMENT AND THE INSURANCE  
22 DEPARTMENT IMPOSE A PENALTY FOR THE SAME VIOLATION.]

23 SECTION 9. THE ACT IS AMENDED BY ADDING A SECTION TO READ:  
24 SECTION 2184. REGULATIONS.--THE DEPARTMENT MAY PROMULGATE  
25 REGULATIONS AS NECESSARY AND APPROPRIATE TO CARRY OUT THE  
26 PROVISIONS OF THIS ARTICLE.

27 SECTION 10. SECTIONS 2191 AND 2192(4) OF THE ACT ARE AMENDED  
28 TO READ:

29 SECTION 2191. COMPLIANCE WITH NATIONAL ACCREDITING  
30 STANDARDS.--NOTWITHSTANDING ANY OTHER PROVISION OF THIS ARTICLE

1 TO THE CONTRARY, THE DEPARTMENT SHALL GIVE CONSIDERATION TO [A]  
2 AN INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S DEMONSTRATED  
3 COMPLIANCE WITH THE STANDARDS AND REQUIREMENTS SET FORTH IN THE  
4 "STANDARDS FOR THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS"  
5 PUBLISHED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR  
6 OTHER DEPARTMENT-APPROVED QUALITY REVIEW ORGANIZATIONS IN  
7 DETERMINING COMPLIANCE WITH THE SAME OR SIMILAR PROVISIONS OF  
8 THIS ARTICLE. THE INSURER OR MA OR CHIP MANAGED CARE PLAN,  
9 HOWEVER, SHALL REMAIN SUBJECT TO AND SHALL COMPLY WITH ANY OTHER  
10 PROVISIONS OF THIS ARTICLE THAT EXCEED OR ARE NOT INCLUDED IN  
11 THE STANDARDS OF THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR  
12 OTHER DEPARTMENT-APPROVED QUALITY REVIEW ORGANIZATIONS.

13 SECTION 2192. EXCEPTIONS.--THIS ARTICLE SHALL NOT APPLY TO  
14 ANY OF THE FOLLOWING:

15 \* \* \*

16 (4) THE FEE-FOR-SERVICE PROGRAMS OPERATED BY THE DEPARTMENT  
17 OF [PUBLIC WELFARE] HUMAN SERVICES UNDER TITLE XIX OF THE SOCIAL  
18 SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396 ET SEQ.).

19 SECTION 11. REPEALS ARE AS FOLLOWS:

20 (1) THE GENERAL ASSEMBLY DECLARES THAT THE REPEALS UNDER  
21 PARAGRAPH (2) ARE NECESSARY TO EFFECTUATE THIS ACT.

22 (2) THE FOLLOWING ACTS AND PARTS OF ACTS ARE REPEALED TO  
23 THE EXTENT SPECIFIED:

24 (I) SECTION 630(E) AND (F) OF THE ACT, INsofar AS  
25 THEY ARE INCONSISTENT WITH THIS ACT.

26 (II) THE ACT OF DECEMBER 29, 1972 (P.L.1701,  
27 NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION  
28 ACT, INsofar AS IT IS INCONSISTENT WITH THIS ACT.

29 (III) 40 PA.C.S. CH. 61, INsofar AS IT IS  
30 INCONSISTENT WITH THIS ACT.

1 (IV) 40 PA.C.S. CH. 63, INsofar AS IT IS  
2 INCONSISTENT WITH THIS ACT.

3 (V) ALL OTHER PARTS OF THIS ACT ARE REPEALED INsofar  
4 AS THEY ARE INCONSISTENT WITH THIS ACT.

5 SECTION 12. CONTINUATION IS AS FOLLOWS:

6 (1) EXCEPT AS OTHERWISE REQUIRED TO COMPLY WITH THIS  
7 ACT, ACTIVITIES INITIATED UNDER ARTICLE XXI OF THE ACT PRIOR  
8 TO THE EFFECTIVE DATE OF THIS SECTION SHALL CONTINUE AND  
9 REMAIN IN FULL FORCE AND EFFECT AND MAY BE COMPLETED UNDER  
10 ARTICLE XXI OF THE ACT ON AND AFTER THE EFFECTIVE DATE OF  
11 THIS SECTION.

12 (2) CONTRACTS AND OBLIGATIONS ENTERED INTO UNDER ARTICLE  
13 XXI OF THE ACT PRIOR TO THE EFFECTIVE DATE OF THIS SECTION  
14 SHALL NOT BE AFFECTED OR IMPAIRED BY THIS ACT.

15 (3) ORDERS, REGULATIONS, RULES AND DECISIONS OF THE  
16 DEPARTMENT OF HEALTH WHICH WERE MADE UNDER ARTICLE XXI OF THE  
17 ACT PRIOR TO THE EFFECTIVE DATE OF THIS SECTION AND WHICH ARE  
18 IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION SHALL REMAIN  
19 IN FULL FORCE AND EFFECT AND SHALL BE ENFORCED BY THE  
20 DEPARTMENT UNTIL REVOKED, VACATED OR MODIFIED BY THE  
21 DEPARTMENT UNDER ARTICLE XXI OF THE ACT.

22 SECTION 13. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

23 (1) THE FOLLOWING PROVISIONS SHALL TAKE EFFECT  
24 IMMEDIATELY:

25 (I) SECTION 11 OF THIS ACT.

26 (II) SECTION 12 OF THIS ACT.

27 (III) THIS SECTION.

28 (2) THE ADDITION OF SECTION 2153 OF THE ACT SHALL TAKE  
29 EFFECT JANUARY 1, 2023.

30 (3) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT JANUARY

1 1, 2024.